EXHIBIT 3

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
CIVIL ACTION NO. 1:23-cv-00480-CCE-LPA

PLANNED PARENTHOOD SOUTH ATLANTIC, ET AL.,	)
Plaintiffs,	)
vs.	)
JOSHUA STEIN, ET AL.,	)
Defendants,	)
-and-	)
PHILIP E. BERGER, ET AL.,	)
Intervenor-Defendants.	)

VIDEOTAPE DEPOSITION OF

MONIQUE WUBBENHORST, M.D., M.P.H.

1:16 P.M.

WEDNESDAY, AUGUST 30, 2023

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RALEIGH, NORTH CAROLINA

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I N D E X

E X H I B I T S

P R O C E E D I N G S

* * *

THE VIDEOGRAPHER: We're now on the record. The time is 1:16, August 30th, 2023. This is the video deposition of Dr. Monique Wubbenhorst. Case name is Planned Parenthood South Atlantic, et al., v. Joshua Stein, et al.

Counsel, if you would please introduce yourselves.

MR. MENDIAS: This is Ryan Mendias with ACLU on behalf of Dr. Beverly Gray, one of the plaintiffs in this case.

MS. AMIRI: Brigitte Amiri also with ACLU representing Dr. Gray.

MS. GRAUNKE: Kristi Graunke, ACLU North Carolina, representing all plaintiffs.

MR. BENJAMIN WOOD: Benjamin Wood, law student intern at the ACLU of North Carolina.

MR. BOYLE: Ellis Boyle, Wake County Bar, representing the legislative leader defendants, Senator Berger and Speaker Moore. Kevin, you're up.

MR. MOORE: South --

MR. WILLIAMS: This is Kevin Williams

and -- on the Zoom and I am representing defendant District Attorney Jim O'Neill.

MS. PAYNE: Julia Payne --

MS. O'BRIEN: Good after- --

MS. PAYNE: -- with Alliance --

MS. O'BRIEN: Good afternoon. I'm -- if I could just go after Kevin. Good afternoon. I am Elizabeth O'Brien. I'm representing the remaining district attorneys in the lawsuit.

MS. PAYNE: Julia Payne with Alliance Defending Freedom representing the legislators.

MR. MICHAEL WOOD: This is Michael Wood. I am counsel to Secretary Kinsley from DHHS.

MR. BULLERI: This is Michael Bulleri. I am counsel for the North Carolina Medical Board and the North Carolina Board of Nursing.

MS. SALVADOR: This is Anjali Salva- --

MR. MOORE: This is South --

MS. SALVADOR: Oh, go ahead.

MR. MOORE: Sorry. This is South Moore, North Carolina Department of Justice,

representing Attorney General Stein.

MS. SALVADOR: This is Anjali Salvador with Planned Parenthood Federation of America representing Planned Parenthood South Atlantic. Also on the Zoom from Planned Parenthood Federation of America are Kara Grandin, Peter Im, and then the 11W-13 is a conference room with our paralegals, Vanisha Kudumuri and Shealyn Massey.

THE REPORTER: Is that everyone?

* * *

MONIQUE WUBBENHORST, M.D., M.P.H.,

having been first sworn or affirmed by the court reporter and Notary Public to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. MENDIAS:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. My name is Ryan Mendias and, like I said, I'm an attorney with the ACLU. I represent Dr. Beverly Gray, one of the plaintiffs in this case. So just some initial housekeeping questions.

You understand that you're under oath and that you have a legal obligation to answer everything truthfully and completely?

A. Yes.

Q. I'll ask that you wait until I finish my question before you start answering and that way we can avoid talking over one another.

A. Yes.

Q. And if you don't understand a question, please let me know. I can rephrase or repeat it and I'll do so.

If you do answer a question without asking for clarification, I will assume that you've understood it, okay?

A. Yes.

Q. And so please answer all questions verbally as you've been doing instead of shaking your head or saying uh-uh or uh-huh.

And so during this deposition your attorney may object, but his objections are just for the record. So after he makes them, you should proceed to answer the question.

A. Yes.

Q. And if at any point you realize that an answer that you previously gave wasn't

complete or wasn't fully correct, you should feel free to stop me and we can go back and discuss the answer again.

Does that sound all right?

A. Thank you. Yes.

Q. Okay. And if you don't do so, we can assume that you stand by the accuracy and completeness of your questions?

A. Yes.

Q. Great. And if you need a break, please let me know. We can definitely do that but -- as long as there's not a question pending. If there is a question pending, you'll need to answer the question and then we can proceed to the break.

A. Yes.

Q. Okay. Is there anything today that would prevent you from giving a full and accurate testimony, medications, illness, anything like that?

A. No.

Q. Okay. Is this the first time you've given a deposition?

A. No.

Q. When have you given depositions before?

A. I gave a deposition in 2017 for a Texas case.
Q. Is that the only deposition that you've given?
A. Yes.
Q. Okay.
A. No. I've given one deposition when I was a resident that -- no, I wasn't a resident. It was -- I graduated from residency. It was around 1995 or 1996.
Q. What was the subject of that deposition?
A. It was an infant that had delivered in the hospital when -- while I was a resident.
Q. Was it a malpractice case? What -- what sort of case was it?
A. Yeah, I think it was a malpractice case. I wasn't very educated about legal questions at that time.
Q. Were you a defendant in that case?
A. The hospital that I did my residency at, which was Yale New Haven Hospital, was the def- -- defendant.
Q. Have you ever participated -- oh, I'm sorry. Did you have more to add to that?
A. I -- I'm not a lawyer so I'm just making sure I say the right thing.

Q. Sure. Sure. Have you ever participated in a lawsuit as a defendant?
A. No.
Q. Have you ever participated in a lawsuit as a plaintiff?
A. No.
Q. Have you participated in a lawsuit in any other capacity?
A. No.
Q. Well, I assume you've participated as an expert witness in --
A. Oh, as an expert witness --
Q. Yes.
A. -- but not where it was me --
Q. Not as --
A. -- personally.
Q. -- a party?
A. Right.
Q. Okay. And when have you participated as an expert witness in previous lawsuits?
A. You mean -- not speaking to giving a deposition, just being involved? Okay.
Q. Correct.
A. So let's see. Kentucky -- for the state of Kentucky, for the state of Minne- --

Minnesota. The cases were in the state of Kentucky, state of Minnesota, state of Kansas. And I feel like I'm forgetting one. Kentucky, Minnesota, Kansas. Oh, and Texas, as I said, uh-huh.

Q. And in your role as an expert, have you testified in court?

A. Yes.

Q. In which of those cases did you testify in court?

A. Texas.

Q. Any others?

A. No.

Q. And have you testified before any legislative body?

A. Yes.

Q. Could you say more about that testimony that you gave.

A. Yes. The Senate Judiciary Committee in -- 2007, 2008, or 2009 was their -- I'm sorry. I --

Q. That's all right.

A. -- don't know. And then the House of Representatives last fall and the Senate in April.

Q. And what was the nature of the testimony that you gave before those legislative bodies?
A. I was testifying on the -- abortion safety and maternal mortality.
Q. And is it fair to say that the expert opinions that you offered in those cases that we just discussed were in support of laws restricting or regulating abortion?
A. I don't -- no, I don't think so because I think that in the Senate case, as I understood it, it was a -- regarding legislation that was being proposed that would remove abortion restrictions, as I understood it.
Q. Right. So I think my question is more specifically about the cases in which you've been an expert witness so Kentucky, Texas --
A. Oh. Oh. Oh. Yes.
Q. -- Minnesota.
A. Right.
Q. And in those cases, you were offering an opinion in support of abortion restrictions; is that correct?
A. Yes.
Q. And the piece of legislation in the Senate

that you mentioned, is that the Women's Health Protection Act?

A. That's correct.

Q. And were you in favor or opposition of that --

A. I was --

Q. -- act?

A. -- in opposition. I'm sorry. Didn't mean to --

Q. Oh, no, no.

A. -- speak too early.

Q. Totally fine. Thank you. So you're aware that the Speaker of the North Carolina House of Representatives and the President of the North Carolina Senate have intervened in this litigation to defend the constitutionality of several laws relating to abortion; is that --

A. Yes.

Q. Okay. So if I say the intervenors, can we agree that I'm referring to those individuals, the Speaker and the Senate President?

MR. BOYLE: Object to form.

A. I'm sorry. I don't understand what you mean.

Q. So I might refer to the intervenors, who your

attorney here is counsel for --
A. Uh-huh.
Q. -- as the intervenors. When I say the intervenors, I mean the President of the North Carolina Senate --
A. Uh-huh.
Q. -- and the Speaker of the House of North Carolina's House of Representatives.
A. Yes.
MR. BOYLE: Object to form. You can answer.
BY MR. MENDIAS:
Q. So when were you first contacted by counsel for intervenors about participating in this case?
A. I would have to look at my scheduler.
Q. Was it months ago, weeks ago?
A. Let's see. This is now August. It was no more than two months ago, but, again, I -- I can't -- you can't hold me to that because I would have to look at my scheduler. I -- I don't want to not respond truthfully.
Q. I understand. Thank you. Who have you been communicating with regarding this -- your participation in this case?

A. Julia Payne, who's counsel for ADF, and Attorney Ellis.
Q. And are you being paid for your participation in this case?
A. Yes.
Q. How much are you being paid?
A. $700 an hour.
Q. And roughly how many hours have you spent preparing for this case so far?
A. More than 30.
Q. And did you bring anything with you to this deposition?
A. Yes.
Q. What did you bring?
A. I brought my declaration, which is here. Would you like to see it?
Q. No. It's all right.
A. Okay. And then I brought ACOG Practice Bulletin 193, a study by Alisa Goldberg, a study by Ushma Upadhyay, and a study by Karen Borchert.
Q. Okay. And I have my own copy, but I think the answer will be yes.

MR. MENDIAS: But I will just ask that this be marked as Exhibit B.

(WUBBENHORST EXHIBIT B, Declaration of Monique Chireau Wubbenhorst, M.D., M.P.H., was marked for identification.)

BY MR. MENDIAS:

Q. But can you confirm that this is an accurate copy of the declaration that you submitted in this case.

A. It looks as though it is, yes.

MR. MENDIAS: Oh, and then I have a copy for you, Ellis, as well.

MR. BOYLE: Thanks.

BY MR. MENDIAS:

Q. Can you please describe the process of drafting this declaration.

A. The process. In other words, how I arrived at my opinion? Is that what you mean?

Q. I mean more specifically how you went about writing the -- this particular document.

A. So I had at hand the declarations from Dr. Alsle- -- Dr. Boraas, actually, I'm sorry, and Dr. Farris. I reviewed those, I reviewed the studies that they cited, and then I did a literature search on the topics that they discussed, used the snowball technique to add additional studies and used

the -- distilled those into my declaration and my opinion.

Q. And what keywords did you use in doing that search?

A. I looked at abortion complications. I looked at terms abortion plus complications, abortion-related mortality, ectopic pregnancy, pregnancy of unknown location. And there -- I'm sure there were others, but those -- those were the major -- some of the main ones.

Q. Did anyone provide any particular studies they wanted you to cite in this expert declaration?

A. No.

Q. Did anyone ask that you include a particular fact or opinion in this declaration?

A. No.

Q. And I'd like to talk about your CV, which I will ask to be marked, please.

(WUBBENHORST EXHIBIT C, Curriculum Vitae, was marked for identification.)

MR. MENDIAS: Thank you.

BY MR. MENDIAS:

Q. Is this an -- look like a -- oh, sorry.

MR. BOYLE: Thank you.

BY MR. MENDIAS:

Q. Does this look like an accurate copy of the CV that was attached to your expert declaration?

A. Yes.

Q. Okay. And I note that the date is May 25th, 2023.

A. Uh-huh.

Q. Is this the most recent version of your CV?

A. No, there's a more recent version.

Q. What would have changed between that version that you submitted and -- and the most recent version?

A. I think I discovered an error in my previous CV. There was a hospital that I worked at in North Carolina that I hadn't listed on my CV. It's -- I believe it was Moses Cone Hospital. I'm actually in the process of updating it now.

Q. And when did you work at Moses Cone Hospital?

A. 2004, 2005. I was there once as a locum tenens.

Q. And I note on your CV as well that you're a fellow of the American College of

Obstetricians and Gynecologists, which I'll refer to as ACOG; is that accurate?

A. Yes.

Q. And what is ACOG?

A. It is a professional organization that many -- I think most OB/GYNs but not all belong to in the United States.

Q. And you've presented papers at ACOG conferences; is that correct?

A. That's correct.

Q. Do you believe that ACOG is a reliable source of information for OB/GYNs?

A. Not always.

Q. On which topics is it not reliable?

A. I think that in terms of their abortion advocacy, they do not always reflect the -- the, I would say, preferences and practices of their constituency.

Q. Are there any other topics besides abortion that you find ACOG to be unreliable on?

A. I haven't reviewed all of their literature so I couldn't answer that.

Q. But of the literature that you've reviewed, you find it all reliable except for abortion; is that correct?

A. I think that there are some areas that I couldn't bring to mind at this exact moment where I would say that they have not cited all of the available literature.
Q. Is there -- can you give any inkling as to what those areas might be?
A. I would have to go back because I haven't looked at those areas recently.
Q. I understand. To be a member of ACOG, does a -- an OB/GYN need to express any particular view of abortion?
A. No.
Q. So ACOG then has members who are opposed to abortion?
A. Actually, the vast majority do not perform abortions.
Q. My question was whether they have members who are opposed to abortion.
A. Yes, they do.
Q. Great. You also indicate on your CV that you're a member of the American Association of Pro-Life Obstetricians and Gynecologists, which --
A. Yes.
Q. -- I'll refer to as AAPLOG; is that correct?

A. Yes.
Q. And you actually served on their board. Is that right, too?
A. Yes.
Q. How long was your time as a board member?
A. I want to say about three years.
Q. And was it continuous or did you have various stints as a board member?
A. No. It was continuous.
Q. And what did your duties as a board member of AAPLOG include?
A. They were most -- similar to any board. We oversaw the activities of the organization, coordinated with the CEO, reviewed scientific papers that AAPLOG put out, among others. AAPLOG is A-A-P-L-O-G. Yeah.
Q. Thank you for that. Could a physician become a member of AAPLOG if they did not oppose abortion?
A. I don't know.
Q. What if I -- I'm going to introduce another exhibit. This, I believe, is Exhibit -- so...

MR. MENDIAS: Thank you.

(WUBBENHORST EXHIBIT D, AAPLOG Mission

& Vision Statement, was marked for identification.)

BY MR. MENDIAS:

Q. Does this look like the mission and vision statement of AAPLOG?

A. It does.

Q. Okay.

A. But I can't confirm that because I haven't looked at it in a while.

Q. Okay. Do you remember what the mission and vision of AAPLOG was when you were on the board?

A. I think similar to what's here. And, again, not being able to quote it because it's been some time, it was to defend the lives of the pregnant mother and her unborn child.

Q. And that necessarily means prohibiting abortion in most circumstances, correct?

A. Yes.

Q. Okay. And I actually have another exhibit.

(WUBBENHORST EXHIBIT E, AAPLOG Practicing Physician of any Specialty Form, was marked for identification.)

BY MR. MENDIAS:

Q. And, Dr. Wubbenhorst, do you recognize this

document, if not necessarily its particular form, what it is with respect to AAPLOG?

A. Yeah. I haven't -- I -- it's been a while since I've seen this so I don't know if this is the current one or not.

Q. But when you say one, what -- one of what? What do you mean?

A. Well, this looks like the form that you would use to join --

Q. Okay.

A. -- but it's been -- I've been a member for some time so I can't speak to this.

Q. But you would have filled something similar out when you became a member, correct?

A. Yes.

Q. And physicians joining the organization while you were on the board would have filled out a similar form --

A. Uh-huh.

Q. -- correct?

A. Yes. Sorry.

Q. And could you read the first sentence under the heading, Practicing Physician of any Specialty?

A. Practicing Physician of any Specialty --

Physicians of any Specialty are those Physicians (either M.D. or D.O.) who agree with our mission statement and su- -- support AAPLOG with annual dues and donations.

Q. And as we just discussed, AAPLOG's mission statement includes prohibiting abortion; is that right?

A. I don't think it's prohibiting abortion. I think it's restricting abortion or advocating for the life of the mother and the unborn child.

Q. Okay. So restricting.

You were also on the board of Americans United for Life, which I'll refer to as AUL; is that correct?

A. That's correct.

Q. You're currently on the board?

A. Yes.

Q. And what are your duties on that board?

A. So it is to oversee the -- the board oversees the activities of the organizations -- of the organization and also works with the CEO in accomplishing its mission.

Q. And what is the mission of AUL?

A. It is to serve as the architects of the

pro-life movement or --

Q. And -- I'm sorry. Did you have more to say that --

A. No.

Q. Apologies if I cut you off at all. When you say, architects of the pro-life movement, what does that specifically mean?

A. Well, I think I'm not articulating very clearly, you know, what the mission is. That's kind of what I would call the general way that they -- general -- how they're seen and how they see themselves. I would have to review the curr- -- the mission statement to give you a precise answer. I don't want to give you an imprecise answer.

Q. So speaking generally, what is it that the organization hopes to accomplish in this country?

A. It supports legislation supporting the life of the wo- -- woman and her unborn child.

Q. And is it true that AUL advocates for what they call abortion abolition?

A. I don't know.

Q. Does AUL believe that abortion should be a matter of state law as opposed to something

regulated at the federal level?
A. I think that they consider both pathways -- I'm sorry. I saw your cup that said, Pathways, and that's what came into my mind. I think they consider both strategies.
Q. And whether it's a pathway or a strategy, what is the ultimate goal of AUL?
A. I think it's to promote life.
Q. Not to ban abortion nationwide?
A. I would say that if you were to ask members of the board and people working in the organization that, similar to AAPLOG, it is to advocate for the life of the unborn child and for the mother.
Q. Okay. I'm -- I'm going to play a video briefly and I'll ask the court reporter how best to --

MR. MENDIAS: Do you mind if we go off the record to discuss how we do this? We can...

THE VIDEOGRAPHER: Going off the record. The time is 1:37.

(Discussion off the record.)

THE VIDEOGRAPHER: Back on the record. The time is 1:37.

MR. MENDIAS: All right. And I will mark this as the next exhibit.

(WUBBENHORST EXHIBIT F, AUL Video Clip, was marked for identification.)

(Video played and stopped.)

BY MR. MENDIAS:

Q. Dr. Wubbenhorst, do you believe that that fairly represents the mission of AUL?

MR. BOYLE: Objection. Are you saying that's an AUL document?

MR. MENDIAS: It -- I am, yes.

MR. BOYLE: Can you establish that first, please. Sorry. Not to --

BY MR. MENDIAS:

Q. Does this -- or do you recognize this video at all?

A. Yeah. I have seen it, yes.

Q. And it is from AUL?

A. Uh-huh.

Q. Correct?

A. I'm sorry. Yes.

Q. Thanks. So do you believe that this accurately encapsulates the mission of AUL?

A. Yes.

Q. Do you agree with this mission?

A. Yes.
Q. And so I take that to mean that you personally oppose abortion in all circumstances?
A. Yes.
Q. In fact, you believe that abortion is a moral and social evil, correct?
A. Yes.
Q. Is it fair to say that you believe abortion is murder?
A. I think it's a nuanced question. I think that if you are saying -- and, again, I'm not a lawyer, but are you referring to the mother who has the abortion or are you referring to the abortionist who performs the abortion?
Q. Let's deal with them one by one. Do you think a woman who seeks and obtains an abortion has committed murder?
A. No.
Q. Do you think a physician who performs an abortion has committed murder?
A. Yes.
Q. Do you believe that what you might call elective abortions should be illegal in all circumstances?

A. Yes.
Q. Does that include cases where the pregnancy is the result of rape or incest?
A. Yes.
Q. And that would include cases no matter the age of the rape victim?
A. I'm sorry.
Q. Would you oppose abortion in a case where pregnancy is the result of rape or incest when the rape victim is a child?
A. Yes, because I have taken care of minors who were the victims of incest who chose to carry their children to term and said that this -- they -- in particular, they've told me two things. They said that, without this baby, I would not have evidence that he did it, and, I also feel that this child is redeeming this circumstance -- this terrible circumstance that has happened to me.
Q. Do you believe that all child victims of rape feel the same way about carrying their rapist's baby to term?
A. I can't speak for how all child victims feel.
Q. Do you think it's possible that some would not feel that way?

A. I think it's possible.
Q. And do you think that delivering a child is the only way to establish the paternity of a rapist?
A. I'm not understanding your question. Without DNA, how would you establish paternity?
Q. Do you believe that DNA can only be obtained from a child that has been delivered?
A. I think that there are techniques now for confirming paternity, but at the time that I was speaking of with these children, that technology was not available.
Q. Do you think that when an abortion is performed, a -- that there is a way to determine forensically who the rapist was based on the products of conception?
A. That's not what I'm -- what I was saying. I was telling you what a patient had actually told me.
Q. Okay. But you would agree that after an abortion, the products of conception can be used to identify the rapist?
A. Yes.
Q. And do you believe that all abortions, even those that have no medical complications,

cause harm to women?

A. Yes. That's based on my clinical experience of caring for thousands of woman. I've never met a woman who was happy that she had an abortion. Relieved? Yes. Feeling as though she couldn't do anything else? Yes. But all women to one degree or another were damaged by that experience, some very damaged, some not so much.

Q. When you say women were relieved, what about their relief made you think that they were damaged?

A. Because they all expressed sorrow at having undergone the abortion and many of my patients report that every year when that child would have been born, they have a ceremony to mourn their death.

Q. What percentage of patients would you say have disclosed to you that they had an abortion?

MR. BOYLE: Object to form.

BY MR. MENDIAS:

Q. You can answer.

A. I'm not understanding the question. You mean if I asked -- you -- you're talking about

patients that I ask?
Q. How did you come to know that those patients had had abortions?
A. I routinely ask them.
Q. And in answering that question, do you then ask how they felt about their abortion experience?
A. I do.
Q. All of them?
A. Yes.
Q. Are you currently practicing medicine?
A. Yes.
Q. Where?
A. Indiana.
Q. Where specifically in Indiana are you practicing medicine?
A. Saint Joseph's Regional Medical Center.
Q. And what do you do there?
A. I'm a hospitalist there.
Q. And what does that mean?
A. I cover the labor floor in shifts and any women that come in through the emergency room or come into triage or who are laboring, I provide backup for the other clinicians or we have our own practice where we care for those

patients in labor as well. And I also practice internationally.

Q. You don't perform abortions, do you?

A. No.

Q. And you've never performed an abortion?

A. No.

Q. Have you ever observed a physician performing an abortion?

A. Yes.

Q. How many?

A. One.

Q. In residency were you offered the opportunity to learn how to perform an abortion?

A. Yes.

Q. And you declined that opportunity?

A. Yes.

Q. What -- have you ever induced labor in a pregnant patient before the fetus was viable?

A. Yes.

Q. In what circumstance would you have to do that?

A. Would I or have I?

Q. Have you?

A. Where a woman had infection and needed to be delivered because she had clear signs of

chorioamnionitis.
Q. And do you remember how far along in her pregnancy this patient was?
A. She was between 21 and 23 weeks.
Q. You don't consider induction in that circumstance to be an abortion?
A. No, because of the principle of double effect.
Q. Could you say more about what that is.
A. It means that when your intention is to save the life of the mother, the outcome of fetal death may be an unavoidable and tragic consequence, but that is not the intent, whereas, in abortion, the intent is clearly the death of the unborn child.
Q. Where -- do you think that some physicians would call induction in that circumstance an abortion?
A. I can't say.
Q. How do you --
A. I think they would. I think there are some people that would say that.
Q. Have you ever performed a dilation and curettage procedure on a patient?
A. Yes.

Q. In what circumstances have you performed a -- a dilation and curettage?
A. Can you be more specific? Are you referring to a living fetus or a dead fetus?
Q. I'm talking about any time that you've performed that particular procedure.
A. Yes.
Q. So in what circumstances have you performed a D&C, either for a living or dead fetus?
A. Hemorrhage, a woman who was infected with a demised fetus in the second trimester. And I -- if you can clarify, you're referring strictly to D&C in pregnancy, not D&C in a nonpregnant woman?
Q. Correct.
A. Okay.
Q. Thank you for that clarification. So have you ever performed a D&C when there is embryonic or fetal cardiac activity?
A. No.
Q. Do you believe that physicians who perform abortions are degraded by the pos- -- procedure?
A. I do. And I have a great deal of sympathy for them. I feel that many people -- it's --

it's very interesting. When you look at statistics, people graduate from residency and a high percentage stopped -- planning to do abortions and a high percentage stopped doing abortions within five years. And I think others really feel very -- speaking to physicians who were abortionists who then decided to leave -- stop becoming abortionists, they've described to me how they felt terrible going to work every day, they felt morally conflicted, so I have a great deal of sympathy for them.

Q. About how many physicians who previously provided abortions but no longer do have you spoken to?

A. Five.

Q. Five. When you provide medical care in the hospital, you've -- do you encounter patients who were referred to your care from the emergency room?

A. Are you -- you're talking about obstetrical patients?

Q. Correct.

A. Yes.

Q. And throughout your career, how many do you

think you have encountered who are transferred from the ER to your service?

A. So you're referring to my current practice in the first -- let me -- when you asked me the question the first time, you said right now. Are -- were you referring to my current practice?

Q. I'm not sure if I said right now and if I did, I misspoke. I meant throughout the entirety of your medical career.

A. Have I -- just to make sure I understand, so have I cared for patients who were referred through the emergency room?

Q. Correct.

A. Yes.

Q. And my question is, about how many over your --

A. Thousands.

Q. Thousands. Is it more than 10,000?

A. No, less than 10,000. Somewhere between probably 5- and 10,000.

Q. And about how many of those patients were in North Carolina?

A. I would have to think because I practiced in nine hospitals in North Carolina but a total

of close to 30 hospitals elsewhere. So it -- I -- I would have to think about that.

Q. If I give you a few seconds or a minute, do you think you could come up with a ballpark?

A. It would be quite a few. It would be quite a few, yeah.

Q. Would you say closer to a hundred or a thousand?

A. It would be more than a hundred, probably considerably more than a hundred --

Q. So --

A. -- because I was a solo practitioner at many of these hospitals when the covering OB/GYN went out of town.

Q. And so would it be closer to 500 or a thousand?

A. It's somewhere in that range, yeah.

Q. Okay. And so out of all the patients -- now I'm talking in any hospital in any state that you've described as --

A. Or country.

Q. -- in -- or country. I -- I would like to limit in -- to the United States so any state.

A. The pathologies are the same, though.

Q. Sure. I'm specifically wondering about patients transferred from emergency rooms to your obstetrical service.
A. Right.
Q. Does that -- does that alter the number of patients --
A. No, because I've practiced --
Q. -- you --
A. -- more here than --
MR. BOYLE: Object to form. You can answer.
BY MR. MENDIAS:
Q. Sure. So I believe you said it was thousands of patients throughout your career.
A. Yeah. I've been in practice more than 30 years.
Q. Okay. And of -- out of those thousands of patients, how many have you encountered who were experiencing complications from an induced abortion?
A. None from an induced abortion. From procedural abortion, yes.
Q. Okay. From an abortion of any kind?
A. Yes.
Q. How many?

A. Two.
Q. Two.
A. No. More than two. Yeah, more than two. Let me just think for a minute.
Q. Sure.
A. I'd say ten or less.
Q. Ten. Dr. Wubbenhorst, do you recall earlier you said that you were -- you participated in a deposition in Texas?
A. Yes.
Q. Is that correct? Okay.

MR. MENDIAS: So I'm going to mark the transcript of that deposition as an exhibit.

(WUBBENHORST EXHIBIT G, Deposition Transcript of Monique Chireau, M.D., October 14, 2017, was marked for identification.)

BY MR. MENDIAS:
Q. So, Dr. Wubbenhorst, you'll see that the numbers are on the top right of each page and that there are four pages per printed page. So direct you to Page 138. So it would be in the top right. Are you there?
A. Yes.
Q. Okay. So beginning with Line Number 9, there's a question. Have you ever managed a

patient who is experiencing a complication from an induced abortion?
A. Yes.
Q. Your answer was, Yes?
A. Uh-huh.
Q. And then the question was, How many times?
A. Right.
Q. And then you answered, Probably four times.
A. Yes.
Q. So are you suggesting now that it was actually ten times or have --
A. No. I've seen --
Q. -- there been --
A. -- more patients --
MR. BOYLE: Objection.
A. -- with --
MR. BOYLE: You can answer.
A. Yeah. I'm not suggesting that this was incorrect. I'm saying that I've seen more patients since then.
Q. Okay. Where have you seen those patients?
A. Internationally.
Q. Internationally. In the United States, have you seen any patients --
A. No.

Q. -- suffering from -- okay. And have you seen any patients experiencing complications from an abortion of any type in North Carolina?
A. No.
Q. So just because I know that your CV might be a little out of date, I wanted to ask, are you currently a senior research associate at the Center for Ethics and Culture at the University of Notre Dame?
A. Yes. Well, my job title has changed. I think I'm a senior fellow.
Q. Okay. What does that position entail?
A. I use -- I'm still do- -- I'm doing research and so I have an office at Notre Dame and I have access to -- I work with people in the center on different projects and I use Notre Dame's considerable resources to carry out my research.
Q. What sort of research do you do?
A. Women's health epidemiology, demography, maternal mortality.
Q. Do you -- would you say that abortion is a focus of your research?
A. No. It's one focus.
Q. So I -- I asked if you would say abortion is

a focus of your research and I just want to be clear. What is your answer?
A. I'm just clarifying that it's one focus.
Q. Okay. So you consider it to be a focus of your research?
A. Yes.
Q. Have you ever served as a peer reviewer for a publication?
A. Multiple publications, yes. I think that's in my CV as well. You've seen that.
Q. Yeah. What do you understand the purpose of peer review to be?
A. In peer review what we attempt to do is to evaluate papers for their research methods, their applicability to the general literature and so on, and decide whether they should be published.
Q. Have you ever published a peer-reviewed article or paper on the topic of abortion?
A. No.
Q. Are you familiar with the complication rate for abortion in North Carolina?
A. Yes.
Q. And what is it?
A. I would have to look at my deposition, but I

believe that the -- the overall complication rate is listed by CDC. I would have to look at the -- the exact data to be sure.

Q. So are you familiar with the abortion reporting requirements in North Carolina?

A. Yes.

Q. What are they?

A. They state that abortionists need to report the com- -- their complications and -- to the North Carolina Department of Public Health as I understand it.

Q. And are you familiar with the pregnancy-associated death rate in North Carolina?

A. Yes.

Q. And can you say what that is?

A. I would have to just confirm it. I don't want to give you a wrong number.

Q. When you say confirm it, do you mean in your declaration or --

A. I believe I brought that up in my declaration, but, again, the maternal mortality rate is -- it depends on -- when you say, pregnancy-associated death rate, I think those are two different numbers. The

pregnancy-associated death rate would include deaths in the first trimester, for example, from ectopic pregnancy. It would also include deaths from abortion and it would include maternal deaths toward the end of gestation as well and those are three very different numbers.

By far, the number that we have the best data for, in my opinion, is maternal mortality. We have -- our data on -- on deaths due to ectopic pregnancy and abortion is very limited.

Q. So during your testimony before the court in Kentucky last year -- do you remember testifying in --

A. Yes.

Q. -- Kentucky? -- you described treating preeclamptic women.

A. Yes.

Q. And you testified that if a woman was getting sicker, you would deliver her. Sometimes depending on the capacity of the place you were when you were delivering her, you might have to call helicopters or planes or ambulances to transport the woman and her

infant to a better-equipped hospital.

Does that sound correct?

A. Yes.

Q. And I think your specific testimony was that you had done so plenty of times. Does that sound right?

A. Yes.

Q. About how many times, if you had to estimate, have you had to transfer -- we can just pick one of those forms of transportation -- transfer a woman via ambulance to a place where she could get care that could not be provided where you had delivered her?

MR. BOYLE: Object to form. You can answer.

A. I would say for ambulance transfers, most of the places where -- most of the facilities where I worked where I had to transfer patients, time was of the essence so relatively few ambulance transfers and more helicopter or plane transfers.

Q. If you had to give a ballpark, could you?

A. For both?

Q. Yes, please.

A. I would say somewhere between 20 -- somewhere

around 20 --
Q. For ambulance?
A. -- patients.
Q. Oh, that includes both?
A. Yes.
Q. And could you be more specific within that 20 how many were in ambulances, how many were in helicopters?
A. Helicopters or planes, probably ten to a dozen and then maybe ten to -- probably not as many as -- I would have to think about it a little bit more.
Q. Okay. So --
A. Again, mostly, those were in places like South Dakota or remote parts of Arizona.
Q. And you'd say -- so eight to ten is maybe a fair ballpark for how many --
A. For?
Q. For ambulance transfers.
A. I would have to really think about it, yeah.
Q. All right. So in your declaration you cite five examples of patients transferred from Planned Parenthood South Atlantic, which I'll call PPSAT, that -- their Chapel Hill clinic to UNC Hospital between February 2022 and May

of 2023; is that --
A. Yes.
Q. Yes? Okay. Do you have firsthand knowledge of these patients?
A. The patients who were transferred?
Q. Yes.
A. No.
Q. How did you learn of these hospital -- or these ambulance transfers?
A. I don't remember exactly how I came across them. I think that when I was looking at the question of hospital transfers, transfers from facilities to hospitals, this information popped up and then I started to dig a little bit deeper into it and found the 9-1-1 transcripts.
Q. I notice in your declaration you cite for one of these ambulance transfers a website called operationrescue.org.
A. Yes.
Q. Did they all come from Operation Rescue?
A. No.
Q. And Operation Rescue is an antiabortion organization, correct?
A. Yes. I don't know very much about them.

Q. Okay. Are you aware that the man who murdered Dr. George Tiller, an abortion provider in Kansas, in 2009 asserted that he was affiliated with Operation Rescue?
A. I can't speak to that.
Q. Are you aware of any other ambulance transfers from any of PPSAT's clinics during the period of February 2022 to May 2023?
A. I'm not.
Q. Do you know how many abortions PPSAT provided between February 2022 to May 2023?
A. No.
Q. If you were to go about calculating the rate of hospital transfers per abortion patient, how would you do that?
A. Hospital transfers from PPSAT Chapel Hill?
Q. Correct.
A. I think that what I would look at is how many abortions were performed and how many ambulance transfers actually occurred.
Q. So in your declaration you also say that it's an axiom in medicine that physicians should not perform procedures if they are not able to manage their complications.

Do you agree with that statement?

A. That's correct for most procedures.
Q. Which procedures does it not apply to?
A. I think that a good example is screening colonoscopy because with screening colonoscopy, if a patient undergoes a perforation, that's usually a -- a complication that would be managed surgically.
Q. So you don't believe that colonoscopies should always be performed in hospitals?
A. No, I don't.
Q. Why not?
A. Because I think that the available literature shows that the complication rate for colonoscopies is much lower than for, say, induced abortions, especially abortion in the second trimester, and most abortion -- second-trimester abortion procedures -- I'm sorry, second abortion tri- -- second-trimester abortion procedures can become very complicated very quickly.
Q. And you don't believe that a rupture of -- or a perforation of a patient's colon can become very serious very quickly?
A. I think that it can be, but I think that when

you look at complication rates and types of complications, it -- including especially where uterine perforation has occurred with damage to vascular structures, perforation has occurred with damage to bowel and bladder, which I've personally had to care for patients with those complications, the rationale for doing those procedures in -- as well as potential anesthesia complications, the rationale for doing those procedures in a hospital is re- -- is much clearer.

Q. As an obstetrician/gynecologist, if someone had a perforation of their colon during a colonoscopy, they would not ever be transferred to your service for care, correct?

A. No.

Q. Do you know the complication rate for perforations in the course of a colonoscopy?

A. I would have to look at my declaration because I believe that that was a question that I discussed in my declaration. Would you like me to do that?

Q. Sure.

A. Okay. Oh. Yeah. I did not put the

complication rates in here.

Q. Okay.

A. I think that what I had -- the point I was trying to make in my declaration about colonoscopy safety was that Dr. Farris cited a paper to try to compare colonoscopy complications to abortion complications, but the particular paper that she cited did not focus on colonoscopy complications. It was looking at risk stratification to arrive at an outcome measure so that outpatient facilities could be profiled in terms of what their rates of unplanned hospital visits were. It did not have as its purpose the estimation of overall incidence of complication. So that was why -- that was why I felt that that particular paper was not speaking to the question of being able to compare abortion complications with colonoscopy.

Q. Understood. But you didn't then look for the complication rate?

A. It was in the -- it was in the -- I'm sorry. What -- what's your question?

Q. The -- that after -- in the course of

drafting your declaration, you did not look up the --

A. Oh, no, I did.

Q. -- complication rate --

A. I did. I didn't put --

MR. BOYLE: Let -- let him finish the question.

A. Oh, I'm sorry. Sorry. Sorry. Sorry. Sorry.

Q. That's all right. So my question is, in the course of your declaration, did you look up the complication rate associated with perforations during a colonoscopy?

A. Yes, I did.

Q. But you did not include that in your declaration?

A. No. There was a lot of other ground to cover.

Q. Do you know what the mortality rate of an outpatient colonoscopy is?

A. No.

Q. Do you know what kind of sedation is typically used in an outpatient colonoscopy?

A. Mild to moderate.

Q. And do you know if tissue is ever biopsied

during a colonoscopy?
A. Yes.
Q. And how would the person performing the colonoscopy go about biopsying that tissue?
A. They use a hot snare.
Q. And what does that mean?
A. It's a either loop or -- or they -- they may use a punch. They either use a loop or a punch device to obtain a biopsy of what they consider might be malignant tissue or even nonmalignant if it's an adenoma -- I mean, a polyp.
Q. And what is the process like of removing that tissue or potential malignancy from the colon?
A. As I said, they use a snare or they use a biopsy forcep. They snip the biopsy and then they -- if there's bleeding, they may or may not cauterize it or they may use something else to achieve hemostasis.
Q. So other than abortion clinics, do you know whether North Carolina inspects outpatient health centers that perform procedures or surgeries?
A. I don't know for sure because I haven't

researched the information, but I do know that ambulatory surgical centers have an accreditation and inspection process.

Q. Are you aware of how frequently ambulatory surgical centers receive notices of deficiencies following those inspections?

A. No.

Q. Do you know what kind of sedation is provided in outpatient surgical facilities in North Carolina?

A. Ambulatory surgical centers?

Q. Yeah.

A. So at ambulatory surgical centers they have anesthesiologists and anesthetists so they provide the full gamut of anesthesia from general anesthesia to sedation.

Q. So what is general anesthesia?

A. So general endotracheal anesthesia is where a patient is paralyzed and intubated and the ventilator breathes for them.

Q. And I believe you said deeper sedation.

A. Deep sedation.

Q. Deep sedation. What do you understand that term to mean as you've used it in your declaration?

A. It typically means that a patient will receive a combination of barbiturate and -- b-a-r-b-i- -- okay. -- barbiturate and narcotic and will put them into a state of profound relaxation. They won't feel pain and their breathing will slow. In general, deep sedation is a procedure that should be performed with an anesthetist or an anesthesiology -- anesthesiologist present because those patients can rapidly decompensate and require intubation.

Q. And what do you understand moderate sedation to be as you used that term in your declaration?

A. The line -- the line between mild and moderate simply means that the patient is still able to breathe on their own and they can often respond to you when you speak to them, whereas, with deep sedation, they usually can't. They have -- can maintain -- they can manage their secretions and breathe on their own.

Q. And what medications are used to achieve this level of sedation?

A. There's a wide variety.

Q. And I meant to ask earlier. What medications are used to achieve general anesthesia?
A. There is a wide variety. I'm not an anesthe- -- anesthesiologist.
Q. Okay. Do you know what kind of sedation is provided to abortion patients at PPSAT's clinics?
A. My understanding is that they provide mild, moderate, and deep sedation according to their own information.
Q. What information specifically are you referring to?
A. Their protocols.
Q. When you say, protocols, can you be more specific? How did you come to read these protocols?
A. My understanding is that -- I believe that she said in -- somewhere in -- one of -- Dr. Farris said in one of her declarations that that's what they provide.
Q. So you have not seen anything produced by PPSAT itself on this topic?
A. Yes, I have.
Q. Distinct from Dr. Farris's declaration?
A. Yes.

Q. How did you obtain those documents?
A. I was given to them -- I saw them through the discovery process.
Q. In this case?
A. Yes. But I have seen them also in other cases as well, in particular the Texas case, and there was one other case where I'd seen them as well.
Q. And you believe that the protocols in Texas are comparable to the protocols in North Carolina?
A. In general, my experience with Planned Parenthood is that they seek to standardize their procedures as much as possible across different affiliates. So if I'm recalling correctly, I had seen these in Texas and I may have seen them in another case as well. I just can't remember which one.
Q. Okay. Thank you. And do you know what kind of medications PPSAT uses to achieve the levels of sedation that they provide to their abortion --
A. No.
Q. -- patients? Sorry. As -- I'm not sure that the court reporter got your answer.

A. No.
Q. Thank you.
A. Yeah.
Q. So in Paragraph 180 of your declaration you say that during the first six weeks of pregnancy is when maternal morbidity and mortality are highest.

Can you explain what you meant by that.

A. I think that what that is -- the -- I'm referring to -- not referring to the entirety of pregnancy; I'm referring to the first trimester.
Q. Sorry. Can you just read that sentence that begins, Deaths during.
A. It says, Deaths during the first six weeks of pregnancy when maternal mortal- -- morbidity and mortality are highest are kept classified as maternal deaths and placed together with deaths due to births and delivery.
Q. So you're not asserting that the first six weeks of pregnancy are the most dangerous part of the entire period of pregnancy, are you?
A. No. What I'm saying is that the first six weeks of the first trimester are the most

dangerous because that is typically when ectopic pregnancies occur.

Q. And in Paragraph 238 of your declaration, which I believe is on Page 41 in the upper right-hand corner --

A. Yes.

Q. -- you say that, Carrying a pregnancy to term is safer than an abortion.

Do you believe that that's true?

A. Yes.

Q. Do you -- as you mentioned earlier, you submitted a declaration in a Minnesota case in September of last year; is that right?

A. Yes.

Q. Okay.

MR. MENDIAS: And I'd like to mark that as the next exhibit.

(WUBBENHORST EXHIBIT H, Declaration and Expert Report of Monique Chireau Wubbenhorst, M.D., M.P.H., Minnesota Case, was marked for identification.)

MR. BOYLE: Thank you.

MR. MENDIAS: Thanks.

BY MR. MENDIAS:

Q. So on Page 10, Paragraph Number 47, can you

read that paragraph.

A. Yes. It is my opinion that without an accurate estimate of the number of abortions performed in the United States or the number of maternal deaths from abortion, it is impossible to estimate abortion-related mortality with any precision.

Q. Do you agree that that's true?

A. Yes.

Q. If it is impossible to estimate the true abortion-related mortality with any precision, how are you now able to say that abortion is more dangerous than childbirth?

A. Because if we look at the available data, and the study I'm thinking of in particular is the Bartlett study which shows that the risk of death from abortion increases 38 percent by every additional gestational -- week of gestational age, that is not -- and that by the end of midtrimester, the risk of death is 76 times greater than that -- than risk of death in the first trimester. There is no corresponding increase -- there is no increase in risk in pregnancy that corresponds to that risk.

And another study, I believe it was by Lidiro, but don't quote me, found similarly that there is a 30 percent increase in death from abortion by -- with each additional gestational week.

So what that says is that as you proceed in gestation, the risks of abortion increase exponentially, not just linearly but they increase exponentially, and that is not the case for mortality in pregnancy.

Q. Do you believe that people regularly obtain abortions in pregnancy at the point in which childbirth is most dangerous or in which pregnancy is most dangerous?

A. Can you --

MR. BOYLE: Object to form.

A. I'm not sure I understand your question.

Q. That was a very confusingly worded question --

A. Yeah.

Q. -- on my part. When do people typically obtain abortions?

A. Well, this is an important question. Most people -- so 93 percent of abortions in the United States are performed -- 91 to 93

percent are performed before the first trimester. And this is a significant problem in ascertaining maternal complications and death because the lar- -- much larger number of abortions that are performed in the first trimester when risk for mortality and morbidity is lower basically drowns out all of the additional morbidity and mortality that's occurring in the second and third trimester. We know that those abortions occur because Warren Hern advertises on his website that he does abortions up to 36 weeks so we know that that happens. We know that those occur.

We also know that simply based on uterine and maternal physiology, the risk of abortion at higher gestational ages is higher and is not amenable to intervention because the difference between a fetus at six weeks -- an unborn child at six weeks and an unborn child at 36 weeks is there's an astronomical difference. You know, you're talking about several grams -- 15 grams versus eight -- you know, somewhere between six and eight pounds. So I think that that's

the basis of that statement.

MR. BOYLE: Not immediately necessarily, but can we take a break at some point? It's been about an hour.

MR. MENDIAS: Sure. I'm -- if you would like to take a break now --

THE WITNESS: Yeah, because you haven't asked another question --

MR. MENDIAS: Sure.

THE WITNESS: -- so this might --

MR. MENDIAS: Okay.

THE WITNESS: -- be a good place.

MR. MENDIAS: Great.

THE WITNESS: Thank you.

THE VIDEOGRAPHER: Going off the record. The time is 2:16.

(Whereupon, there was a recess in the proceedings from 2:16 p.m. to 2:30 p.m.)

THE VIDEOGRAPHER: Back on the record. The time is 2:30.

BY MR. MENDIAS:

Q. Doctor, during the break did you speak with anyone about the deposition so far?

MR. BOYLE: Objection. To the extent she spoke with me, that's work product and I

would instruct her not to divulge anything that we spoke about.

BY MR. MENDIAS:

Q. Did you speak to anyone other than an attorney --

A. No.

Q. -- during the break? Okay.

A. Well, I said hello to the front desk person.

Q. Did you consult -- did you consult any studies or materials during the break?

A. No.

Q. So before we broke, you had mentioned Dr. Hern. And your testimony was that he performs abortions through 36 weeks; is that right?

A. The last I saw on his website, yes.

Q. Does Dr. Hern practice in North Carolina?

A. No.

Q. Is abortion permitted through 36 weeks in North Carolina?

A. No.

Q. If a woman is pregnant and is considering whether to have an abortion or to carry to term, isn't the relevant comparison for the mortality associated with abortion at eight

weeks versus -- I'm sorry. I might have omitted that from -- so I'll withdraw that question.

If a woman is pregnant at eight weeks and is considering an abortion, if she is deciding between carrying to term and delivering and having an abortion, isn't it relevant for her to compare the mortality associated with an abortion performed at eight weeks with mortality associated with childbirth?

A. No, it's not relevant at all.

Q. Why?

A. Because the mortality from abortion at eight weeks -- the more relevant comparison would be abortion at term or near term and maternal mortality at the same gestational age.

Q. For that patient making the decision, you believe that is the relevant comparison?

A. I guess I'm not understanding your question. Are you saying that if -- if a woman is looking -- wanting to understand what is abortion-related mortality? Can you please clarify?

Q. If a woman is eight weeks pregnant and is

deciding between continuing a pregnancy or having an abortion at eight weeks --

A. Right.

Q. -- isn't it relevant for her to compare the mortality associated with an abortion at eight weeks with the mortality associated with childbirth?

MR. BOYLE: Object to form.

A. So the mortality at eight weeks when the fetus weighs 50 -- 15 grams is not applicable or similar in any way to an abortion close to term, as I said earlier, where the fetus weighs five or six pounds, maybe seven pounds. And abortion, as we've said, has a 38 percent -- the risks of mortality increase exponentially, by 38 percent, for each week of gestational age so I don't think that's an accurate comparison.

I think the second problem with that reasoning is that you cannot predict for any given patient what their -- you know, risk is a population-based assessment. It's not an expression of whether an individual patient will have an outcome or not. So you can't say that, well, this patient had an abortion

and it kept her from having gestational diabetes because you simply can't predict for any individual patient with any certainty that they will have a specific outcome.

Q. It's true that a person who has an abortion will not suffer any complication from pregnancy after that -- after the point in which they had an abortion, correct?

A. Because you've performed the abortion and they're no longer pregnant, but that's not the point. The point of this discussion is often that you can perform an abortion to prevent maternal morbidity and mortality and that's just not true. Number one, because we know that where abortion is legal -- and the specific examples that I'm aware of are Chile during the Pinochet regime, Ireland, and Malta. They had -- especially in Malta where abortion is banned for any reason, they've had zero maternal mortality for five years. Same thing in Ireland. Ireland had one of the lowest rates of maternal mortality in the world prior to them legalizing abortion and the same thing in Chile.

So it doesn't follow from that argument

that if you do an abortion, it's going to lower maternal mortality or reduce maternal morbidity.

Q. It's true that some women have preexisting conditions that put them at very high risks of negative outcomes during pregnancy, correct?

A. Yes, that's correct. But you cannot say to someone with diabetes, you're going to develop diabetes and have a diabetic coma or if you have high blood pressure, you're going to develop preeclampsia and die. You simply cannot do that. All of our assessments of risk are population based; they are not predictive for an individual.

Q. What is the risk that a woman with pulmonary hypertension dies during pregnancy?

A. 50 percent.

Q. Do you believe a woman deciding whether or not to have an abortion when she has pulmonary hypertension might consider the risk associated with abortion versus the risk of a pregnancy in which there's a 50 percent chance of dying?

MR. BOYLE: Objection and object to

form.

A. I guess --

MR. BOYLE: You can answer.

A. Okay. So your question -- let me just rephrase your question back to you. So you're saying that that woman should -- are you saying that she should have the option to have an abortion because she -- of her -- the 50 percent risk of mortality?

Q. That's a good question. Do you think that she should?

A. I don't believe that abortion is -- elective abortion is -- as -- as you've said before, I don't agree with elective abortion. I think that in the patient with pulmonary hypertension, if she develops worsening symptoms saying she could be delivered, that's certainly an option.

Q. If a woman with pulmonary hypertension becomes pregnant and not yet experienced any negative outcome from her hypertension, you don't think that she should be permitted to have an abortion?

MR. BOYLE: Objection and object to form. You can answer.

A. Yeah. I -- I -- I could not speak to that situation. I think that, as I said, if she became pregnant and she continued to carry the pregnancy, she became symptomatic to the extent that she needed to be delivered, then that's an appropriate management plan.

Q. In Paragraph 196 of your declaration --

MR. BOYLE: Is this Exhibit B?

MR. MENDIAS: Yes.

A. Okay. Let me just read --

Q. Sure.

A. -- back so I can get context here. Okay. Yes.

Q. Can you read the last sentence of that paragraph.

A. In other words, the authors made estimates for a substantial number of caseloads using sources such as media stories which weakens the validity of their study.

Q. Why do you believe re- -- relying on media stories is inappropriate --

MR. BOYLE: Object to form.

BY MR. MENDIAS:

Q. -- in this context?

A. Because what we're talking about here is

epidemiology and epidemiology -- rather than being based on what a media story says, epidemiology ideally looks at patient-level data.

Q. So in your report you provide the names of women you say died following an abortion. Did you have firsthand knowledge of any of these women?

A. No.

Q. How did you first learn about these deaths?

A. I was, again, as I said earlier, looking at data on abortion-related mortality and came across the names of these women and I felt that it was truly tragic that young, healthy women underwent abortions that related -- resulted in their deaths.

Q. Did you find information about these women's deaths in newspaper articles?

A. No. I found their -- can you just remind me where that is?

Q. Sure. That is in Paragraph 188.

A. Yes. No. These were not -- I think in one situation, it was -- the -- the first one, it was a -- it was an article from the New York Daily News.

Q. And in Subparagraph 7 you also cite the New York Times, correct?
A. Yes.
Q. You also cite a website called abortiondocs.org. Do you know what that is?
A. This was a website that had information, and I believe this one had a autopsy report as well.
Q. Do you know anything else about that website?
A. No.
Q. Did you review the medical charts of any of these women?
A. No. I reviewed the autopsy reports as they were presented on the internet.
Q. How many of them had autopsy reports?
A. I would have to count, but it looks like one, two, three, four, five, six -- six or seven. And then --
Q. Which --
A. -- the others had depos- -- were from a deposition, another one was from an EMS report, and two were from -- oh, I just saw the numbers are out of order. Okay.
Q. Did any of the autopsy reports or articles that you consulted detail the women's medical

histories?
A. Yes.
Q. Which ones?
A. All of the autopsy reports. That's routine with autopsy reports.
Q. Do you know how much time elapsed between the abortion procedure and the complications --
A. I would have to look at --
Q. -- each women suffered?
A. -- each -- I would have to look at each one. I'm sorry. Sorry. Did not mean to cut you off.
Q. Are you aware of any women who died following second-trimester abortions in hospitals?
A. Yes. I think I mentioned a couple of those.
Q. Can you specify which ones occurred in hospitals?
A. I believe Keisha Atkins did and I believe -- in fact, I'm pretty sure -- I would have to look at the autopsy reports but -- I believe that most of these women died in hospital, but I would have to confirm that.
Q. Oh, I'm sorry. My question was, do you know if any of the abortions were performed in hospitals?

A. I think that information was in the autopsy reports, but I would have to reread them.
Q. But you didn't include any of that information in the declaration, did you?
A. No.
Q. Do you know how many abortions were performed at the clinics where these patients received their abortions?
A. No.
Q. Throughout your report you cite studies that suggest that a woman is at a high risk of suicide following abortion; is that right?
A. I think that the more precise way of expressing it is that there is evidence that in- -- there are increased risks for suicide among women who've undergone abortion.
Q. So to be clear, you're not arguing that abortion causes suicidality?
A. I would say that more accurately that there is an association between abortion and suicidality, yes.
Q. And so what is an association?
A. Association can be positive or negative, but it does not necessarily -- to -- it doesn't address the issue of causality. It's a -- it

indicates that there is an association.

Q. Is an association synonymous with a correlation?

A. Not exactly, no.

Q. How do they differ?

A. Correlation means that you compare one set of outcomes or one set of values with another to see if the relationship is linear or colinear or nonlinear so it's a -- it's a slightly different -- slightly different way of approaching it.

An association is simply that you can have a positive or a negative association between an exposure and an outcome.

Q. Doctor, what is the American Psychological Association, if you know?

A. The APA? Yeah.

Q. Correct.

A. It's an association of -- I don't know -- I know of the organization's existence. I don't know whether they are the same as ACOG or as a professional society. I can't speak to that.

Q. Do you believe that they're a reliable source?

A. I can't speak to that either. I do know that they've engaged in considerable abortion advocacy starting in 1979.
Q. What makes you describe their -- what makes you describe what they do as advocacy?
A. One of their statements that they made in 1979 was that they felt that abortion was -- and I'm paraphrasing. I would have to look at the exact quote. But they made statements strongly supporting abortion.
Q. Do you believe that a statement either in favor of or in opposition to abortion is necessarily advocacy?
A. I think it depends on how you define advocacy.
Q. How would --
A. I think on some level, what it means is that -- when an organization engages in pro-abortion statements, it means that it's worth looking very carefully at their statements and the particular conclusions they draw regarding abortion.
Q. Do you believe the same applies to organizations that oppose abortion?
A. Yes. I think that you have to look at the

quality of the science that they're proposing and I think that in some studies, for example, because this is a contentious topic, some researchers will -- will look -- will provide -- will look at both -- will look at what's called the null hypothesis, which is in their research to say, you know, we're -- we're not going to assume a benefit or a risk; we're just going to approach this agnostically to try to account for that.

Q. Do you consider yourself an advocate?

A. No. I would say my advocacy more falls in terms of scientific advocacy.

Q. But you would describe yourself as a scientific advocate then?

A. No, I would not. I would say that I am interested in looking at the science, critiquing the science, and applying the science appropriately.

Q. But you engage in advocacy?

A. I don't engage in formal advocacy efforts as in -- I think I would -- if you can define what you mean by advocacy, that would help me to answer the question.

Q. All right. Well, earlier, in response to one

of my questions you referred to, my advocacy, and so I'm just wondering what you mean by that.

A. I'm -- I'm sorry. I don't remember -- if she can read the question, that would be helpful.

Q. Sure.

MR. MENDIAS: Would you mind doing that, Lisa?

(The following question and answer were read back:

Q: Do you consider yourself an advocate?

A: No. I would say my advocacy more falls in terms of scientific advocacy.)

A. Right. So what I would say is that my advocacy is for women and children. That's what I'm about. To the extent that that impinges on the question of abortion, yes, but I've devoted my career and my life to serving women, especially vulnerable women, vulnerable children, women in socioeconomic deprivation and otherwise. So that's the source of my advocacy and the reason for it.

Q. Have you ever testified before Congress on a topic unrelated to abortion?

A. No.

MR. MENDIAS: All right. So I'm going to mark this as an exhibit.

(WUBBENHORST EXHIBIT I, Article, The facts about abortion and mental health, American Psychological Association, was marked for identification.)

MR. BOYLE: Thank you.

MR. MENDIAS: Thanks.

BY MR. MENDIAS:

Q. And so this is the APA, and it has said that, More than 50 years of international psychological research shows that having an abortion is not linked to mental health problems, but restricting access to safe, legal abortions does cause harm.

You consider that statement to be advocacy, correct?

A. I'm sorry. I -- I started reading it.

Q. Oh, apologies.

A. Distract- -- got distracted.

Q. I'm sorry.

A. Yeah. Go ahead.

Q. You would consider the statement -- I -- I -- I'm sorry. I'll -- I'll read the statement

again. More than 50 years of international psychological research shows that having an abortion is not linked to mental health problems, but restricting access to safe, legal abortions does cause harm.

Do you believe that that conclusion is advocacy?

A. I can't speak to that because I don't know the intent of the person saying it. I can say that I disagree with that statement.

Q. Are you aware that the APA has cited large longitudinal and international studies which have found that obtaining a wanted abortion does not increase risk for depression, anxiety, or suicidal thoughts?

MR. BOYLE: Objection.

A. I am not -- I haven't -- I haven't seen this particular -- this particular document so I can't really comment on it. When I look at this -- documents like this, I need to look at the studies they're citing, critique their statistical methods, and so on and so forth so I can't really speak to that.

Q. That's fair. Are you familiar with the Turnaway Study?

A. Yes.
Q. And what is it?
A. So the Turnaway Study was a study -- was a survey of women who had undergone abortion at differing intervals over -- out to five years and looked at various outcomes associated with the women who -- women who remained in the study until the -- the end of the study.
Q. And would you agree that it was extremely well-designed?
A. Yes. I think I've stated that, actually.
Q. And --
A. But the best design can't overcome the vagaries of surveys. Survey data is the weakest form of data as opposed to observational studies, clinical trials, and others.

Second of all, the Turnaway Study, as I've said, while it was well-designed, had very significant dropoff to the extent that only 19 percent of patients finished.

And more to the point, by the end of the study, if you look very carefully at the data, 95 percent of women who kept their children said they were happy with their

decision.

Q. Are you aware of the comparable percentage of women who reported life satisfaction after they had obtained abortions?

A. The comparable percent?

Q. (Nods head).

A. I would have to look at it again. I think I cited it in my -- but I think -- again, I would like to come back to the point that the methodological problems associated with Turnaway Study are very significant.

Another important issue, and forgive me if this is not the most current data, is that people have repeatedly requested Turnaway Study -- the authors to put their data in a data repository and to date, as far as I know, they've refused to do that.

Q. Do you know whether there were any significant differences between the women who continued in the study and those who were lost to follow-up?

A. Yes. I think that if you look at the study -- and I would have -- it would be great if I could refer to my -- oh, actually, I don't know if I went into a detailed

critique here. There were differences in gestational age at the time of abortion versus no abortion. And, again, the -- the question really is that if only one in five patients at the end of a study stayed in the study, no matter how well-designed it was -- and I think it was -- it was a very well-designed study, asked a lot of questions, but that cast doubt on the validity of the study simply based on the lack of follow-up.

Q. Do you believe that that's true even if there were no meaningful differences between the women who were lost to follow-up and the women who stayed in the study?

A. You can't make any conclusions. If one -- only one in five patients stayed till the end, you simply cannot draw conclusions.

Q. Are you familiar with a 2018 report published by the National Academies of Science, Engineering, and Medicine concerning the safety of abortion in the United States?

A. Yes.

Q. So in your declaration you criticize it for being funded by abortion advocates; is that

correct?

A. Yes.

Q. Do you believe that a study should be discounted on the basis that the people who funded it have a strong political view of abortion?

A. No. I think that that means that you should scrutinize the methods and the results more carefully.

Q. Are you familiar with the criteria that the National Academies used in deciding whether to include a study in its review?

A. Yes. And I think that they eliminated a vast number of studies that were -- would have spoken to the issue and ended up with a very small amount -- very small number of studies that did not accurately reflect the literature.

They also continued to discuss this statistic of, you know, women are more -- 12 to 14 times more likely to die in childbirth when preg- -- than from abortion when that statistic is based on a paper by Raymond and Grimes which has severe methodological problems. It combines different data sets.

It uses different denominators. It does not use -- does not account for the majority -- I'm sorry. -- does not account for differences in -- in those databases.

So, again, I -- I would have to say that on the merits, the National Academy study suffers from one of the typical problems of systematic evidence reviews and metaanalyses, which is that they're very dependent on what criteria you use for your metaanalysis and how biased those studies are or are not.

Q. You -- I believe the answer was, yes, you are familiar with the criteria that the National Academies used so can you say what criteria those are.

A. I would have to look to be precise.

Q. But when you say you're familiar, you have a general sense of what they used to exclude or include studies?

A. Yes. I think that what they -- they used in their metaanalysis, they used metaanalytic rules that -- again, I would have to look at the study to be precise because I don't want to misquote them. But they -- through their process, the point is that their rules

excluded a very large number of studies that were responsive to the question.

Q. Do you believe that they excluded only studies that showed a -- a -- an association with negative outcomes and abortion?

A. I'm not following your question.

Q. Do you believe they --

A. Will you rephrase, please.

Q. Sure. They -- do you believe that they excluded studies that showed no negative outcomes associated with abortion?

A. Studies that showed no negative -- I -- I would have to go back and look at the studies they excluded. I can't say off the top of my head.

Q. Can you give an example of one criterion that they used to exclude studies?

A. Again, I don't want to misquote. I have read the study in great detail and critiqued its methods, but if you want me to pull up the study and look at it, if you have a copy of it, I'm happy to do that.

Q. I don't so we can continue.

A. Yeah.

Q. In your report you cite a 2009 Finnish study

by Niinimäki, which is N-i-i-n-i-m-a-k-i, called, Immediate Complications After Medical Compared With Surgical Termination of Pregnancy.

A. What -- what paragraph is that?

Q. So that would be Paragraph 32. And did you bring a copy of that study? I forget if that was one of the ones that you said you had.

A. No, I didn't bring one.

Q. So just give me a moment.

MR. MENDIAS: I'm going to mark this as well.

(WUBBENHORST EXHIBIT J, Article, Immediate Complications After Medical Compared With Surgical Termination of Pregnancy, was marked for identification.)

MR. BOYLE: Thank you.

MR. MENDIAS: Uh-huh.

BY MR. MENDIAS:

Q. And in Paragraph 32 you cite this study in support of your claim that first-trimester medication abortion carries substantial risks to the mother; is that right?

A. Yes.

Q. And are you aware what sorts of medication

abortion regimens patients had received in this study?

A. Yes. I think that they used vaginal misoprostol, which is somewhat different from the regimen that's used in the United States; however, there have never been any head-to-head trials to show that that regimen is less safe or more safe or -- there have been -- never been any effectiveness or efficacy trials to compare those two.

Q. So I'm going to direct you to a particular paragraph. So on Page 796, the first paragraph of the column on the right side, do you see the sentence after Footnote 14 that begins, The time of follow-up?

A. Yes.

Q. Would you please read that sentence.

A. The time of follow-up after abortion was 42 days.

Q. Then could you read the next sentence as well.

A. Medical abortion was defined as the use of mif- -- mifepristone alone or in combination with misoprostol or other prostaglandins.

Q. So do you know whether PPSAT uses a

medication abortion regimen different from those methods?

A. I think PPSAT does use a -- an abort- -- a regimen that's different. But, again, as I said earlier, there's never been a head-to-head comparison to show that the efficacy, safety, or effectiveness of this regimen differs from the one used by PPSAT.

Q. Okay. And so returning to the first page, can you read the paragraph after the all caps word conclusion.

A. Both meso- -- methods of abortion are generally safe, but medical termination is associated with a higher incidence of adverse effects. These observations are relevant when counseling women seeking early abortion.

Q. So are you aware that the authors later explained that the study was based on a Finnish health registry that coded all follow-up visits as complications even if those visits were just for additional consultation?

A. Yes, I'm aware of that, but I don't think that's relevant to the point that I was trying to make. The point that I was trying

to make was that the risk of hemorrhage was very significant. It was almost 16 percent. So the risk of incomplete abortion was 6.7 percent and 1.6 percent with surgical abortion. And the risk of emergency surgery was also close to 6.7 -- 6 percent.

So the point I was trying to make was not the study design. It was the fact that these hard outcomes that they looked at including hemorrhage, including need for surgical evacuation, in- -- including risk of incomplete abortion, were higher than surgical abortion and higher than what's reported in the United States.

Moreover, I want to emphasize that these Finnish studies have the advantage of complete ascertainment, which we do not have in the United States ever. They track every woman from birth -- every human being from birth until death, all of their interactions with the medical system, so this is a comprehensive way of looking at all tort -- tor- -- sorts of medical outcomes. I've spoken with Mika Gissler. The research that they do is really excellent and that's the

point I was trying to make.

MR. MENDIAS: So I'm going to mark this.

(WUBBENHORST EXHIBIT K, Letters to the Editor, Immediate Complications After Medical Compared With Surgical Termination of Pregnancy, was marked for identification.)

MR. BOYLE: Thank you.

BY MR. MENDIAS:

Q. Doctor, you mentioned hemorrhage. In the second paragraph on -- in the leftmost column, do you see a sentence in the middle of that paragraph that begins, Based on?

MR. BOYLE: Objection. What -- what are we looking at here?

BY MR. MENDIAS:

Q. This is -- do you rec- -- do you recognize this publication that --

A. Yes. Uh-huh.

Q. Okay. Do you see the paragraph -- the second paragraph in the leftmost column?

A. Yes.

Q. And do you see the sentence about halfway through that begins, Based on?

A. Uh-huh.

Q. Could you --

MR. BOYLE: Objection. Can we -- can we just clarify what it is on the record, please.

BY MR. MENDIAS:

Q. All right. Can you say what this document is.

A. Oh, this is a letter to the editor from -- I'm familiar with this. -- I think her name is Mary Fjerstad to the editors of The Green Journal OB/GYN asking -- presenting some questions for the authors.

Q. Okay. And can you read that sentence we were just talking about.

A. Based on correspondence with the Dr. -- H-e-i-k-i-n-h-e-i-m-o, one of the authors of the Niinimäki -- I'll spell that, N-i-i-n-i-m-ä-k-i, and there's an umlaut over the A -- in Finnish health registries, any return visit, even for additional consultation, is categorized as a complication. Thus, a woman who is bleeding may have been within the normal range but who sought reassurance could have been coded as having had a hem- -- hemorrhage.

Q. So isn't it true that the rates of hemorrhage might have been inflated in the original Niinimäki study?
A. I don't think that's true. This author is making a presumption not based on any data. She said a woman may -- her bleeding may have been in the normal range and could have been coded, but she doesn't present any data or any critique of the data to support that statement.
Q. And the doctor she refers to, Heikinheimo, he was a -- an coauthor of the 2009 --
A. Right.
Q. -- Niinimäki story -- or article?
A. But they don't present the correspondence so I can't comment on that.
Q. How do you define hemorrhage?
A. It depends on the procedure. So typically, you can have as much as -- I mean, again, it depends on the procedure.
Q. Is any amount of bleeding in a patient hemorrhage?
A. No.
Q. So how much bleeding is a minimum to be considered hemorrhage?

A. It's usually prespecified in patients and in clinical data so that's why I'm asking you which procedure you're referring to. For example, if it's a labor-and-delivery patient, we would consider bleeding up to about 400 milliliters to be normal and then once past that, maybe 3- to 400, and then once it's beyond that, we count that as postpartum hemorrhage. So it's procedure specific and in papers, as I said, they usually provide a predefined cutoff as to what they consider to be hemorrhage.

Q. How much bleeding is considered hemorrhage in a medication abortion patient?

A. I think that it's -- they can bleed as much as 80 to 100, but, again -- 100 is -- milliliters. But, again, the amount is subjective. And unless you weigh pads, which is what we do -- weigh pads and surgical sponges and so on and so forth, which is what we do with hemorrhage at term, it is difficult to quantify.

Q. And in the right column of this letter to the editor page, this was written by the authors of the study, Niinimäki 2009, et al.,

correct?
A. Yes.
Q. And can you read the bullet point at the bottom of that rightmost column on the first page.
A. Rate of serious real complications is rare and rather similar between surgical and medical abortion.
Q. And was the 2009 Niinimäki study a retrospective administrative database study?
A. Yes.
Q. And you say a strength of that study is to completely ascertain all abortions and all complications, correct?
A. Yes.
Q. But in your declaration at Paragraph 36, you criticize a study by Upadhyay, et al., from 2015.
A. Yes.
Q. And you specifically say that it has many limitations similar to other retrospective administrative database research studies, correct?
A. Yes. That's because studies that are done in the United States cannot have complete

ascertainment. We don't have the types of databases, we don't have the types of registration, we don't have the types of statistical methodology and power that they do in Scandinavia so they're not com- -- comparable at all.

Q. But didn't Upadhyay in the 2015 study look at Medicaid data which included all Medicaid beneficiaries who had received an abortion and any follow-up care that they obtained?

MR. BOYLE: Objection. You can answer.

A. They're -- the Medicaid databases are notorious. I've worked extensively -- you can look at my CV and see that I have two, maybe three papers looking -- doing heavy power lifts using Medicaid data. Medicaid data is notorious for being limited. There is miscoding. There are patients that, for example, will code for having two deliveries in one year. The ability to -- for them to follow up on patients is -- is not -- it is not comparable in any way to what the Finnish people can do with their databases.

And in addition to that, the Finnish database is designed to capture both medical

and administrative and financial data. Medicaid is designed just to capture financial data. That's it. It's -- it is not -- and it doesn't have information on gestational age, doesn't have information on complications at the patient level. These databases do.

Q. So looking back at the reply that Niinimäki wrote in response to Mary Fjerstad's letter to the editor, isn't it true that she writes that complications -- many of the complications are not really such but, rather, concerns or adverse events that bring women back to the healthcare system?

A. Yes. That's what she says.

Q. Does that imply that there was some miscoding?

MR. BOYLE: Objection.

BY MR. MENDIAS:

Q. You can answer.

A. No, I don't think that there's miscoding because, as I've said, they organize their database very differently from ours and miscoding is very rare if -- and unusual.

What I would say is that the specific

outcomes that I mentioned, which were hemorrhage, incomplete abortion, and emergency surgery, are hard outcomes and they were demonstrated to be more common and they were demonscra- -- -strated to occur at a specific incidence or prevalence within a population that we were looking at.

Q. And you also criticized the 2015 Upadhyay study saying that, There is a likelihood that patients with complications didn't engage with the medical system; is that right?

A. Yes. And what I meant by that was that they did not engage with the medical system in a way that was visible through a Medicaid administrative database. That's the point that I was trying to make. If a patient had complications, of course, they would reasonably engage with the medical system, but the fact of the matter is that what we find very frequently is that when patients suffer abortion complications, they do not return to the abortion clinic. They are seen by physicians like myself who go to hospital emergency rooms and that was the point that I was trying to make, that they did not engage

with the medical system in a way that was visible through a Medicaid database.

Q. In Paragraph -- my -- my apologies. So in general, you criticize record linkage study involving the Medicaid program.

Is that a fair representation of your position in the declaration?

A. I think it's open to critique, but sometimes it's the data that we have. But I do think that it is not adequate to answer certain questions and that's what I'm -- the point I'm trying to make.

Q. So in Paragraph 57 of your declaration you cite a study by Reardon, et al., from 2002.

A. Uh-huh.

Q. That was also a California Medicaid record linkage study, correct?

A. Right. Yes.

Q. Would you agree that the 2015 Upadhyay study was well-designed?

A. I would have to go back and look at the study design because I cannot say off the top of my head whether it was well-designed or not. I don't believe I commented on the study design. I said there were methodologic

issues, but I didn't say whether it was well-designed or not well-designed.

Q. So do you have your Minnesota expert report? And I'm -- apologies. I do not remember what exhibit it was marked as.

MR. BOYLE: H.

BY MR. MENDIAS:

Q. H. So --

A. Oh. Oh. Oh. You already --

Q. Yeah.

A. -- gave it. Okay.

Q. Yeah.

A. Wait a minute. Wait a minute.

Q. So on Page 16 -- or -- I'm sorry. Yes. Actually, Page 16, Paragraph 71. And that would be the fifth line of that paragraph.

A. Yes.

Q. You did say it was well-designed, correct?

A. Yes.

Q. Okay.

A. Uh-huh. And in Paragraph 143 you also criticize another Upadhyay study.

MR. BOYLE: Object to form. What -- what exhibit are you on now?

MR. MENDIAS: It's -- I haven't marked

that exhibit yet. I'm talking about her declaration.

A. But you didn't tell me which --

MR. BOYLE: So you're back to --

A. -- document --

MR. BOYLE: -- Exhibit B?

A. -- we're referring to.

Q. No. No. No. I -- this is another Upadhyay study and I will mark that, but I haven't marked it yet. So --

MR. BOYLE: But you're back in Exhibit B --

MR. MENDIAS: Oh, in Exhibit B --

MR. BOYLE: -- 4- --

MR. MENDIAS: -- yes. Correct.

THE WITNESS: Okay.

MR. BOYLE: -- Paragraph 143?

MR. MENDIAS: Apologies. Yeah.

MR. BOYLE: Yeah. Thank you.

BY MR. MENDIAS:

Q. So Paragraph 143 of your declaration. So in the --

A. Yes. Uh-huh.

Q. So that was a 2018 Upadhyay study?

A. Uh-huh. And I just want to say, I have

nothing against Dr. Upadhyay.

Q. Sure. You point out that it only included data from 15.7 percent of the country.

MR. BOYLE: Objection.

BY MR. MENDIAS:

Q. You can answer.

A. I think that what I said was that it's 15.7 percent of hospitals.

Q. Sure.

A. And then I went on to say, quote -- quote, It undersampled some regions west and south and oversampled others.

Q. Do you have a reason to believe that abortion complications are more likely in some regions of the country than others?

A. Yes.

Q. What would those reasons be?

A. I think that the -- actually, not the complications themselves. I can't really comment on whether the complications themselves would be more likely in different parts of the country, but the management of those complications might depend on the availability of health services.

Q. And so with respect to your criticism that it

only included 15.7 percent of hospitals in the country, are you aware of any data set that includes emergency room data from every hospital in the United States?

A. I think there are data sets like that that exist, but I would have to confirm that.

Q. You've never -- you couldn't provide a name of such a data set?

A. It would be very easy to get that.

Q. Okay. Who do you think maintains this data set?

A. I think the Hospital Association of America has similar data sets. Again, I can't really comment on which ones they are or who maintains them, but I know that they exist.

Q. So the authors of that study say they used data from the nationwide emergency department sample.

Are you familiar with what that is?

A. Yes.

Q. What is it?

A. It is a sampling -- but it's not a random sampling. It's a sampling of emergency department encounters with -- from patients with the medical system through the emergency

department.

Q. And they also, the authors, that is, say that that sample is maintained by the Agency for Healthcare Research and Quality.

Are you familiar with that --

A. Yes.

Q. -- agency? What is that agency?

A. HRQ is an agency of the Federal Government that looks at -- its mandate is health services research in the United States.

Q. Do you believe that it's a reliable source of data?

A. It's reliable to the extent that -- of the data's quality. No source is reliable in and of itself; it depends on data quality and integrity.

Q. Do you believe that the data from the national emergency department sample is of low quality?

A. I haven't reviewed it and I can't really say.

Q. You note as well in your declaration that 15 deaths were noted in the Upadhyay 2018 study; is that right?

A. Can you direct me to where -- where you are --

Q. Sure. That's --
A. -- referring to?
Q. -- Paragraph 146.
A. It says -- yes. It says, 15 patients in the sample had ED visits that ended in the patient's death.
Q. Are you aware what the total sample size was?
A. I would have to look at the paper, but I was not using that statistic as the numerator for an assessment of deaths from abortion. That was not the purpose. The point I was trying to make is that patients present to the emergency room and died in the emergency room. That was the point I was making. I was not making an epidemiologic assessment that this is the numerator over some denominator of encounters in the ER. That's not what I was trying to do.
Q. What was the relevance of the point you were trying to make?
A. That patients presented to the emergency room and died in the emergency room.
Q. Isn't it possible that if a woman did not disclose that she had had an abortion, she would have been excluded from the study

sample?
A. It's possible, but that's speculation.
Q. But you believe that abortion providers tell their patients not to inform emergency departments staff that they've had an abortion?
A. I don't believe it, but I believe that I've documented in my declaration where that has occurred.
Q. Has it occurred in North Carolina?
A. I don't know.
Q. Have you ever seen anything from PPSAT to suggest that it tells its patients such a thing?
A. I would not say that. I have not seen that.
Q. In Paragraph 67 of your declaration --
A. Okay. Give me just a minute here.
Q. Sure.
A. Yes.
Q. -- you assert that aspiration abortion is surgery.
A. Yes.
Q. And in the next paragraph you say, It requires surgical training distinct from other types of training.

A. Yes.
Q. Is that training that you've received?
A. No. But as an academic physician, I was aware of and continue to be aware of the fact that physicians who are being trained to do abortions are trained in surgical technique of doing abor- -- performing abortion.
Q. Do you consider a D&C to be a form of surgery?
A. Yes.
Q. In Paragraph 69 you say, It requires surgical operative sterile technique. What do you mean by that phrase?
A. What are we referring to?
Q. In Paragraph 69 you say, It requires --
A. When you say -- are you referring to surgical abortion?
Q. Well, I -- I'm asking about the paragraph that you wrote so I'm wondering what the it is there and --
A. Right.
Q. -- what you mean --
A. So it's surgical --
Q. -- by that phrase.
A. -- abor- -- oh, sorry. Sorry. I'm sorry.

Q. No. Go ahead. I -- I'm asking you to explain that paragraph in -- both in terms of what it's referring to and what you mean by surgical operative sterile technique.

A. So when surgery is performed, typically, we perform surgery using instruments that have undergone high-level sterilization to prevent the introduction of spores and resistant organisms into body cavities. That is part of operative technique. We also use sterile gloves, sterile gowns, sterile instruments, and sterile conditions, sterile surfaces, and that defines what sterile operative technique is.

Q. And what is curettage?

A. It's French because many of our medical terms are from French or Greek and it means scraping.

Q. Can you explain how that scraping constitutes a, quote, linear incision through the lining of the uterus, end quote, as you assert in Paragraph 71 of your report.

A. Because when you perform an abortion or when you are doing dilation and curettage for retained products of conception, you apply

the curette until you hear something called a cri, c-r-i, and what that is is the sound of you scraping through the layer of the uterus to make linear incisions in the endometrium, the lining of the uterus, down to the beginning of the -- down to the interface between the muscle -- the -- what's -- down to the base of the endometrium. And that is characteristically a gritty sensation that you encounter and that tells you that you've removed the tissue either through an incomplete abortion or whatever procedure you're doing.

Q. And do you consider that scraping to be an incision?

A. It is because you're incising through the lining of the uterus.

Q. Are you aware that ACOG does not describe curettage as involving an incision?

A. I'm aware that ACOG makes that distinction. I don't agree with that.

Q. In Paragraph 74 of your declaration you suggest that, 15 to 20 percent of patients receiving curettage due to an induced or spontaneous abortion develop intrauterine

adhesions, correct?
A. I didn't say that. I quoted these authors as saying that.
Q. And you agree with that statement?
A. Yes.
Q. What is a spontaneous abortion?
A. It's a miscarriage where you have in utero fetal demise.
Q. So the figure that you cite doesn't differentiate between those patients who miscarried and those who obtain an abortion and then subsequently developed intrauterine adhesions, correct?
A. In the paper and in subsequent papers they do make that distinction. The point I was trying to make there is that curettage is surgery and it leads to surgical complications. It leads to scar tissue.
Q. And like you said, you've performed D&Cs for patients experiencing miscarriage, correct?
A. Yes.
Q. Do you know how frequently your patients develop intrauterine adhesions after you perform a D&C?
A. No.

Q. When an embryo or a fetus has died in utero, what are physician -- physician's options for removing it?

A. So I'm going to rephrase it a little bit differently. So if a patient comes to me -- and miscarriage is a very sad situation. Many times women are devastated by the loss of a child that they had already planned and thought about and contemplated their birth. When patients come to me with a miscarriage, I typically offer them the opportunity of expected management versus immediate management with a D&C. Does that answer your question?

Q. Yeah. I think I have a follow-up question, though. What happens if there is fetal death in the second trimester?

A. So with fetal death in the second trimester, we are much more concerned with abort- -- with infection and hemorrhage. And so typically, those patients in my experience in every hospital in every program that I've worked at are managed in the hospital.

Q. And --

A. They're not managed as outpatients.

Q. Have you managed those patients yourself?
A. Yes.
Q. What have you done to manage them?
A. Either -- before misoprostol we would have to dilate the patient's cervix with laminaria and then do essentially a D&E, dilation and evacuation, but not a D&E in the sense that it was not on a living -- it was on a demised fetus. With misoprostol, management has become much more straightforward.
Q. What is management like now that misoprostol --
A. We give them --
Q. -- exists?
A. -- high doses of -- of -- I'm sorry. We give them misoprostol orally. I -- some clinicians may give it vaginally and that usually effects expulsion. E -- that should be e-f-f-e-c- -- thank you.
Q. So in Paragraph 94 of your declaration you discuss a report produced by an organization called Advancing New Standards in Reproductive Health, correct?
A. Uh-huh. I'm sorry. Yes.
Q. And that report was an analysis of a report

produced by the FDA entitled, Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2018, right?

A. Yes.

Q. And you describe as demonstrably false the report's assertion that it is mandatory to report any death among someone who used mifepristone, correct?

A. Yes.

Q. What is your view to arrive at your conclusion that that statement was demonstrably false?

A. I reviewed FDA's REMS for mifepristone and I also reviewed their postmarketing protocols. Their postmarketing protocols are very specific in stating for the REMS that prescribers must report complications to Danco or -- actually, it's not just Danco because there's a generic manufacturer. But let's say for this -- just the manufacturer of mifepristone, prescribers must report those to the -- complications to the manufacturer who then reports them to FDA. But if prescribers are not notified of complications and those complications occur

and are managed in an emergency room or elsewhere, they are never reported. And so, therefore, it is not true. There is no mandate on practitioners, physicians, emergency room docs, gynecologists to report those complications to FDA. That does not exist.

Q. Do you consider yourself an expert on the Federal Food, Drug, and Cosmetic Act?

A. Only an expert insofar as it affects my practice and needing to understand the ways that FDA's mandates and rules affect my practice.

Q. Do the REMS for mifepristone affect your practice?

A. No -- no, because I do not perform abortion. However, it is incumbent to understand, as in this situation, that, as I said earlier, there is no mandatory reporting on the part of everyday pres- -- of -- there's mandatory reporting on the part of prescribers but not on the part of other physicians who may manage those complications. Without having that information, it is impossible to accurately ascertain what the true

complication rate is from mifepristone abortions -- mifepristone/misoprostol abortions.

Q. So between Paragraphs 113 and 114 of your declaration you include a table, correct?

A. Yes.

Q. And that table includes deaths that the FDA was aware of after a patient took mifepristone, correct?

A. Yes.

Q. Does that suggest that those deaths were caused by mifepristone?

A. They were associated with mifepristone.

Q. And what is your basis for saying that they were associated?

A. The statement there under the paragraph -- the second double dagger where it says, The fatal cases are included regardless of causal attribution. So if there is no cause, then you're really talking about association, that the woman took it -- mifepristone and then had -- experienced these outcomes.

Q. But doesn't the paragraph go on to say that some of these deaths involved causes that could not possibly have been associated with

mifepristone?

A. I disagree with that statement because I believe and I think that there's evidence, which I have supplied in my declaration, that women do engage in risk-taking behavior, do engage in unhealthy behaviors which can lead to them dying from drug intoxication, suicide, and so on and so forth.

Q. Do you believe that there's an association between medication abortion and being the victim of a homicide?

A. I think that if a woman undergoes a medication abortion and then engages in risk-taking activities, in particular drug use, and I documented associations between abortion and drug use, that she could put herself in a situation where she could be the victim of homicide.

MR. BOYLE: We've been going for about another hour so whenever it's convenient, I'd like to take a break.

MR. MENDIAS: Sure. I've got a few more questions in this -- on this topic but then after that, maybe ten minutes from now.

A. Yes, because I could use the ladies' room.

Q. So did this report -- or -- I'm sorry. This table here includes all the deaths the FDA was aware of between September 28th, 2000, and June 30th, 2021; is that correct?
A. As far as I know, yes.
MR. BOYLE: Object to form.
BY MR. MENDIAS:
Q. And that was a yes?
A. No. It was -- I said, as far as I know. I can't say yes or no because I wasn't the FDA and I didn't collect the data.
Q. Did the report indicate how many women had taken mifepristone in that period of time?
A. There are two parts to this report and I didn't include everything, but they -- there is a -- somewhere in here there is a denominator. Again, I think that it would be very difficult to identify which -- whether women took mifepristone or not because, again, we are relying on data that were reported to the manufacturer. And as I said earlier, those data are necessarily com- -- incomplete because there is no mandated -- mandated reporting for nonprescribers.
Q. Do you believe that the denominator is

inaccurate that the FDA reported?
A. Can you define what you mean by the denominator.
Q. The number of women who took mifepristone in that time period.
A. I don't know. I haven't reviewed their raw data so I can't say.
Q. Did you encounter a figure that the FDA provided as the number of women who had taken mifepristone in that time period?
A. I want to say it was in the millions and the number 2.6 million comes to mind, but that is recollection so I can't really say that that's completely accurate.
Q. And last month you submitted a declaration in a case in Kansas, correct?
A. Yes.
MR. MENDIAS: Could I mark this as the next exhibit. Thank you.
(WUBBENHORST EXHIBIT L, Declaration of Monique Chireau Wubbenhorst, M.D., M.P.H., Kansas Case, was marked for identification.)
MR. BOYLE: Thank you.
BY MR. MENDIAS:
Q. And so on Page 39 of that declaration --

A. Yes.
Q. -- you include a very similar chart, correct?
A. Yes.
Q. And it reports the same number of deaths and ectopic pregnancies; is that right?
A. Yes.
Q. Just give me one second. And above the chart there is text from the FDA report, right?
A. Yes.
Q. And do you see the number of women indicated there who took mifepristone through the time period covered in the chart?
A. Yes. I think I said earlier it was in the millions.
Q. Great. And what -- how many specifically millions is it?
A. They say approximately 5.6 million.
Q. Why didn't you include that figure in your report for this case?
A. I was at the point where I needed to keep my text as short as possible. It was certainly not because I was trying to run away from that figure. I'm well aware of that figure. It's commonly cited in the literature so it was simply a question of trying to shorten --

keep my testimony as brief and to the point as possible.

Q. And how long is your declaration report -- or, I'm sorry, your declaration submitted in this case? That would be Exhibit B.

A. 64 pages.

Q. Okay.

MR. MENDIAS: I'm willing to take a break at this point.

THE VIDEOGRAPHER: Going off the record. The time is 3:33.

(Whereupon, there was a recess in the proceedings from 3:33 p.m. to 3:49 p.m.)

THE VIDEOGRAPHER: Back on the record. The time is 3:49.

BY MR. MENDIAS:

Q. Dr. Wubbenhorst, do you believe that maternal mortality surveillance relies exclusively on death certificates?

A. No.

Q. And do you agree that the gold standard for ascertaining maternal mortality is to collect data and then have a state-level group of obstetricians and epidemiologists review every case? Correct?

A. I don't think that's the gold standard for ascertaining mortality. I think that that is more related to ascertaining causes of mortality.
Q. Okay. And you -- we were discussing earlier the testimony that you gave in Kentucky. You remember that testimony, correct?
A. I do. I'm thinking you have a copy of it.
Q. I might have given it already, but let me see.
A. I don't believe you've given it yet.
Q. Correct.

MR. MENDIAS: So I'll mark this. Thank you.

(WUBBENHORST EXHIBIT M, Excerpt of Hearing Testimony by Dr. Wubbenhorst, was marked for identification.)

BY MR. MENDIAS:
Q. And this is a transcript of the direct and cross-examination you underwent, I believe, last summer in Kentucky.

Does that look like -- correct to you?

A. Yes.
Q. Okay. And on Page 197 -- so -- and the pages, again, are in the upper right-hand

corner of each small page in the --

MR. BOYLE: So objection. Is there anything to identify this with?

MR. MENDIAS: Yeah. Let me -- well, the witness has said that it looks familiar so I can look for the full copy in a moment but --

A. Yeah. I haven't -- I haven't seen this so...

Q. So on Page 197 --

A. Yes.

Q. Okay. Pardon me one second. All right. Actually, we'll set that aside for the -- a moment. I apologize for that.

Are you aware that the CDC has obtained data on abortion mortality from all 50 states?

A. I -- on abortion mortality. I haven't looked lately but, yes.

Q. Do you know the sources that the CDC relies on to identify abortion-related deaths?

A. They pull from a variety of sources and I would need to look precisely at their actual method section of their MMWR.

Q. Do you know off the top of your head some of those sources even if we'll acknowledge that

it's not all of them?
A. They rely on reports from the states. They rely on death certificate data. There -- there are a few sour- -- data sources that they use.
Q. Do they rely on reports by private citizens?
A. I don't know.
Q. Do you know what happens after the CDC obtains a -- a report of an abortion-related death?
A. My understanding is that they will try to get as much information as they can regarding that death.
Q. And then what happens, if you know?
A. Then they compile their data and report them.
Q. Are you aware of any review of the reports that the CDC undertakes?
A. Well, that's what I meant, trying to get as much information as possible.
Q. Okay. So could you say a little bit more about what you mean when you say they try to get as much information as possible.
A. They will try to get information about things like gestational age and so on and so forth. Again, I don't have their protocol in front

of me so I don't want to try to recite it from memory.

Q. And are you aware of who at the CDC undertakes the review of these reports?

A. I do not know. I would have to look at their report to see that, which should be very straightforward and easy to do.

Q. Okay. So back to Ex- -- Exhibition -- or Exhibit B, your declaration in this case.

A. Just give me a moment. Yes.

Q. So in Paragraph 39 of your declaration you cite a study by Cates and Grimes, correct?

A. Yes.

Q. And that study is to support your assertions about the mortality rate of the D&E abortion procedure; is that right?

A. No.

Q. What is it for?

A. It's to show trends. I was not citing because that study's obviously very old, but I was trying to make the point about methods of D&E -- methods of abortion in the second trimester and trends in how abortion data were collected and so on and so forth. I was not making a comment about mortality per se

in that era compared to this era.

Q. What trend do you think the study exemplifies?

A. I think that it shows that the -- again, using contemporaneous -- their techniques were similar to what we use now, but it showed that their rate -- the increase in mortality in their study was fairly substantial between 13 to 15 weeks and greater than 16 weeks. That was the point that I was trying to make.

Q. So you acknowledge that the study is fairly old and, as you say in your report, it looked at D&E procedures performed from 1972 to 1978, correct?

A. That's correct.

Q. And that was before -- at least some of the abortions in the study were performed before the Supreme Court's decision in 1973 in Roe v. Wade, correct?

A. That's correct.

Q. Do you know the circumstances under which an abortion prior to Roe could be performed in most states?

A. It depended on the state and it was -- it was

not as much of a patchwork as it was that the legalization of abortion proceeded starting with -- I believe was California and New York. I don't know which one was first.

But, again, that's not the point I was trying to make. The point I was trying to make was the change in mortality rates that occurred from 5.6 per hundred thousand at 13 to 15 weeks to 14 at greater than 16 weeks. That's the point I was trying to make.

Q. Do you think that the rates -- the trend that you're discussing might have been affected by the medical procedures used 40 years ago?

A. I think that the D&E procedure they were using then was similar to what we're using now. And in the second part where I talked about installation procedures and prostaglandin and hysterotomy, the point I was making there is that those procedures are actually still used in some states and that they're associated with significantly increased rates of mortality.

Q. Do you believe that PPSAT uses any procedure other than D&E for abortions in the second trimester?

A. Not to the best of my knowledge, but, again, that's not the point I was making. I was looking at overall abortion-related mortality.

Q. Do you believe that advances in medicine could have undermined the conclusions of the study with respect to the trend across gestational ages?

A. I can't speak to that. I can't say what could or could not have happened.

Q. Do you believe that medicine does advance over time?

A. Yes.

Q. And are you aware that the study's authors found that out of 234,000 D&E abortions, there were only 18 deaths?

A. Yes, I'm aware of that. But, again, the point I'm trying to make was not related to mortality rate per se; it was related to mortality rate as it increases with gestational age.

Q. Are you aware that the authors of the study concluded that D&Es performed in nonhospital settings had lower death-to-case rates than those performed in hospitals?

A. I'm aware of that, but, again, that's not the point I was trying to make by citing this study. And, again, the study is not contemporaneous.
Q. And are you aware that the study's authors concluded that comparative mortality data indicate that performing D&E outside of hospitals carries no greater risk of death?
A. Oh, yeah, I'm aware of that, but, again, as you said, this study is how old now?
Q. Doctor, you've expressed doubts with the completeness of the CDC's surveillance of abortion-related mortality; is that correct?
A. Yes.
Q. Are you aware that this study relies on annual abortion surveillance conducted by the CDC at the time?
A. Am I aware of what?
Q. That the study relied on CDC's annual sur- -- abortion surveillance activities when calculating mortality rate.
A. You're talking about the 1991 study?
Q. Yes.
A. Correct. I'm familiar with Willard Cates' and David Grimes's work.

Q. Is it your view that abortion mortality surveillance is more accurate in countries like the United Kingdom with nationalized health systems?

A. No, because I think they have the same problem of ascertainment that we have here and they also have significant problems with issues around miscoding just as we have here. And what I mean by that is that some abortion deaths are coded as being due to pregnancy or natural causes. And an excellent example of that is the unfortunate young lady who I mentioned earlier, Keisha Atkins, who died as -- due to complications from a late -- I believe it was between 38 -- 28- and 32-week abortion who was listed as -- the cause of death was pregnancy. So they suffer from the same issues that we have in terms of miscoding, in terms of inaccurate -- insufficient ascertainment.

Q. To be clear, Keisha Atkins died in the United States, not the United Kingdom, right?

A. But I'm using that as an example of something that I think is a phenomenon common to all abortion statistics and not just abortion,

other causes of death as well.

Q. So why is the ascertainment better in Finland than in the United Kingdom?

A. Because once you enter the health system when you're born, you don't exit it till you die. Every encounter with the medical system is documented and every encounter with the medical system, when researchers go to look at it, they can look at what the coding was and correlate it to a hospital chart if they want to. We do not have those capa- -- capabilities.

Q. Sure. I asked you about the United Kingdom. So do you have any basis to believe in the United Kingdom the surveillance is different than in Finland?

A. It is because the national health service is a national health service, but it does not enroll patients from birth to death and collect comprehensive data on every encounter with the medical system. They can collect data administratively and then try to go back and look at patient-level data, but to have granular patient-level data requires something like what they have in Scandinavia.

Q. Have you examined patient-level data or any health service data from the United Kingdom?
A. Yes, I have looked at some -- some of their data.
Q. In what context?
A. I was interested in some of their maternal mortality data because what their data was showing was that there were disparities in maternal mortality between women of color and white women even though they have a nationalized health system. I have not looked at patient charts because I haven't gotten permission to do that.
Q. Do you believe that the data that you reviewed was inaccurate?
A. It was aggregate data and I can't vouch for its integrity or its quality.
Q. Do you -- are you aware that the authors of the 1981 Cates and Grimes study found that the death case rates for D&E in the United States are consistent with British data?
A. I was not aware of that. And, again, the point of my citing that study was simply to show the difference -- the issues around increasing mortality with increasing

gestational age. That was the point of my citing it.

Q. And in Paragraph 179 of your declaration you cite a source by Lanska. Can you say what that source is.

MR. BOYLE: What paragraph is that, please?

MR. MENDIAS: That was 179.

MR. BOYLE: Thank you.

A. Yes.

Q. What is that source?

A. It's a journal article.

Q. Okay.

MR. MENDIAS: I'm going to mark this, please. Thank you so much.

(WUBBENHORST EXHIBIT N, Letters to the Editor, 2/17/2017, was marked for identification.)

MR. BOYLE: Thank you.

BY MR. MENDIAS:

Q. And, Doctor, this is not a journal article, is it?

A. It's a letter to the editor. That's correct. Yeah.

Q. So it was not peer reviewed?

A. Uh-huh. That's correct.
Q. And the letter was written in 1983, correct?
A. That's correct.
Q. And isn't it true that the only source cited in this article -- or the only sources cited in this article are from 1981 or earlier?
A. That's correct.
Q. And the --
A. The point -- I'm sorry.
Q. No. Go ahead.
A. If I can continue, the point I was making in including these -- including this particular letter is that it's stated in a very clear and understand way that the -- I think it's the first, second -- third paragraph on Page 362 where it says, The mortality rate for vaginal deliver- -- excuse me. Excuse me. The mortality rate for vaginal deliveries may be artificially low because high-risk mothers are more likely to have a cesarean delivery. This effect could be eliminated by adjusting for preexisting medical conditions between the vaginal and cesarean delivery subgroups as the authors did in calculating rates for women who had an abortion.

So the only reason I was including this was not as a way of comparing maternal mortality, which was higher at that time. And certainly, this is, you know, 40 year -- some-odd years ago, but it was easily -- an easy-to-understand way of talking about how high-risk moms are more likely to have a cesarean delivery, which is associated with increased risk for mortality than low-risk moms.

Q. In defining a high-risk delivery, the letter's authors assume that maternal mortality following a cesarean is approximately a hundred per 100,000; isn't that correct?

A. Yes. But, again, I'm not looking at their -- or not citing their specific data. What I'm trying to help to present and perhaps didn't need -- and appreciate the opportunity to make it clearer is that cesarean delivery is associated with a higher mortality rate than vaginal delivery --

Q. Do you believe --

A. -- and that when you combine maternal mortality statistics, very often that

distinction is not made. That's the only point I was trying to make.

Q. Do you believe that the mortality rate today following C-section is a hundred per 100,000?

A. I just said a moment ago that I am not relying on the maternal mortality statistics. I am simply making the point that cesarean delivery is associated with higher mortality and morbidity than vaginal delivery.

Q. I understand. But I'm asking you if you believe that the mortality rate today following a cesarean section --

A. No, it's not.

Q. What do you think it is?

A. I think that the most recent statistics I saw were that the -- I would have to look, but I think the mortality rate for a cesarean delivery is about ten times greater, but, again, I would have to look to be sure of that.

Q. And the authors of the letter conclude that, Cesarean sections account for only 10 percent of deliveries and 90 percent of maternal mortality associated with childbirth; is that right?

A. That was true then, but it's not true right now --
Q. So you're not --
A. -- because we have a much higher -- sir?
Q. No. Go ahead.
A. No. Please complete your question.
Q. I just wanted to confirm. So you don't believe that 90 percent of maternal deaths associated with childbirth are attributable to C-sections today?
A. No, I don't think that that's the case. I think that the other point is that our cesarean rate is much -- what I was going to say is that the -- our cesarean rate is much higher than it was at that point.
Q. Understood. Doctor, what is an ectopic pregnancy?
A. It's an -- ectopic pregnancy, excuse me, is a pregnancy that implants outside of the uterus. It can implant in a variety of other sites, but the majority of them implant in the fallopian tube.
Q. And how common is ectopic pregnancy?
A. 1 to 2 percent of pregnancies in the United States.

Q. What are the risks of an ectopic pregnancy?
A. Rupture with hemorrhage requiring urgent surgical intervention; death; complications of hypovolemia, for example, if she bleeds and then suffers heart attack or other complications as well.
Q. Do you know what the rate of each of those risks is, how frequently they occur in an ectopic pregnancy?
A. I couldn't tell you what -- the risks associated with hypovolemia. I do -- I can affirm that ectopic pregnancy is the leading cause of first-trimester maternal death.
Q. Sure. Do you know the specific rate, how many women per ectopic pregnancy die in this country?
A. No. I think that the point is -- as I was saying earlier, that it's fairly common, happening in 1 to 2 percent, and it is not an easy diagnosis to make always.
Q. Do you know at what point in pregnancy an embryo can be visualized with a transvaginal ultrasound?
A. Depends on the woman. So most pregnancies and the radiology literature state that you

should be able to visualize an embryo sometime between four and six weeks, but it can be longer. Relates to tissue characteristics, to the skill of the operator.

Q. Would you consider a pregnancy of unknown location to be equivalent to a confirmed ectopic pregnancy?

A. No.

Q. And if a patient has a pregnancy of unknown location but no symptoms of ectopic pregnancy, do you consider that a suspected ectopic pregnancy?

A. It's suspected until proven otherwise. That's axiomatic in OB/GYN.

Q. So your opinion is that all pregnancies of unknown location should be assumed to be ectopic until ruled out?

A. Yes, because if you miss it and a woman dies, then that's very bad.

Q. And so you said in your declaration that ectopic pregnancy is a contraindication to medication abortion.

A. That's correct.

Q. Why is it contraindicated?

A. I'm just quoting FDA's -- the prescribing information there.
Q. Do you have your own basis for believing that it's contraindicated?
A. I was just quoting the prescribing information. I'm sorry. I'm just putting this in order. Just my little thing here of --
Q. Uh-huh.
A. -- keeping papers straight. Yeah.
Q. Okay. So you don't have any other knowledge about why it might be contraindicated?
A. No, sir. I'm relying on what the prescribing information states.
Q. Do you believe that mifepristone causes tubal rupture?
MR. BOYLE: Object to form.
A. No.
Q. Do you believe that misoprostol can cause a tubal rupture of an ectopic pregnancy?
A. Not to my knowledge.
Q. Would you agree that an ectopic screening protocol that uses ultrasound and hCG testing is appropriate?
A. Yes.

Q. Do you know PPSAT's protocol for providing medication abortion when there is a pregnancy of unknown location?
A. My understanding is that it relies on ruling out ectopic pregnancy through -- or attempting to rule out ectopic pregnancy based on symptoms and history and not ultrasound.
Q. Do you believe that PPSAT provides medication abortion to patients without having first performed an ultrasound?
A. Yes.
Q. Do you believe that PPSAT provides medication abortion to patients without doing hCG testing?
A. Can I just --
Q. Sure.
A. -- clarify that? So your question was do I believe that PPSAT provides medication abortion to patients without an ultrasound. Yes. In -- in all cases, I don't know.
Q. So do you believe that PPSAT provides medication abortion to patients without doing hCG testing?
A. My understanding and the specific issue that

I was responsive to here was the pregnancy of unknown location. Reading the -- what Dr. Farris said, it appears that PPSAT does not perform -- routinely perform transvaginal ultrasound in a patient with pregnancy of unknown location to rule out ectopic pregnancy.

Q. If a patient seeking medication abortion can't obtain one because she has a pregnancy of unknown location, do you believe that the law's requirement to document an intrauterine pregnancy requires that patient to seek further screening --

A. Can you --

Q. -- for ectopic pregnancy?

A. Can you --

MR. BOYLE: Object to form.

A. Yeah. Can you break that question down? I'm sorry. It's --

Q. Sure.

A. -- long.

Q. So you understand that the law that you are here testifying in support of requires the documentation of an intrauterine pregnancy before a medication abortion can be provided,

correct?

A. Yes.

MR. BOYLE: Object to form. You can answer.

BY MR. MENDIAS:

Q. And if a patient because of that requirement cannot obtain a medication abortion, is it your understanding that anything in the law requires her to seek further screening for ectopic pregnancy?

MR. BOYLE: Object to form. You can answer.

A. I'm really having trouble following you. What -- what do you mean by cannot obtain an abortion?

Q. Well, as you understand, the law does not permit a medication abortion in cases of pregnancy of unknown location, correct?

MR. BOYLE: Object to form. You can answer.

A. That's correct. But if the patient has a pregnancy of unknown location, it's -- you must triage that patient to either a diagnosis of ectopic pregnancy, intrauterine pregnancy, or a failing pregnancy,

miscarriage. It doesn't mean that she can't have an abortion. I don't understand what you mean by that.

Q. If a patient prefers a medication abortion but she doesn't have a documented intrauterine pregnancy, do you believe that she can get an abortion under the law?

A. If she has an ultrasound that diagnoses her to have a living intrauterine pregnancy. If -- if she has -- if -- she could either have an ectopic pregnancy, in which medication abortion would be entirely inappropriate; she could have a miscarriage, in which case medication abortion would be inappropriate because she would have passed that demised fetus on her own or potentially needed follow-up down the road but certainly wouldn't have necessarily needed to -- to be treated for and charged for an abortion; or she has a viable intrauterine pregnancy that she could have an abortion.

So I'm -- I'm just not understanding your question, maybe. Maybe I just don't -- I don't get what you're saying.

Q. You understand that some patients prefer

medication abortion over surgical abortion, correct?

A. Yes. And those patients have the option to get it when an -- a vi- -- an intrauterine pregnancy is seen.

Q. And if they don't have a documented intrauterine pregnancy --

A. Then they must be triaged to a diagnosis of either intrauterine pregnancy, failing pregnancy or miscarriage, or ectopic pregnancy.

Q. And what does triaging mean?

A. You apply the appropriate diagnostic procedures to make -- to identify the location of the pregnancy.

Q. And if a patient refuses to comply with those diagnostic procedures, what happens then?

A. Then you have an obligation to not administer a medication that could -- that she either doesn't need or would not be effective.

Q. Does anything in the law require that woman to then seek ectopic screening elsewhere?

MR. BOYLE: Objection.

BY MR. MENDIAS:

Q. You can answer.

A. I don't understand the -- the legal issue. I mean, I'm here as a witness on medical issues; I can't speak to the legal issue.
Q. Okay. You've read the laws in question?
A. Yes, I have. But, again, I'm -- I'm here to speak to the -- to the -- to the -- the medical issues as an expert.
Q. Okay. So in Paragraph 268 of your declaration...
A. Just give me one moment, sir.
Q. Sure.
A. Yes.
Q. So you say that if a patient's h- -- well, you quote Dr. Farris who says that if a patient's hCG levels are sufficiently high, this may be evidence of ectopic pregnancy, correct?
A. Yes.
Q. And you suggest that implicit in that statement is that the patient must now undergo surgical abortion in addition to medical abortion; is that correct?
A. Okay. What I say is, Implicit in this statement is the fact that because appropriate diagnostic steps to rule out

ectopic pregnancy were not taken at the time of the patient's initial visit, she must now undergo surgical abortion in addition to medical abortion.

Q. So --

A. So that's what I said and what I mean by that is the fact that if the patient had had an ultrasound that could confirm a diagnosis of intrauterine pregnancy, ectopic pregnancy, or miscarriage, she would have not received a medication that she did not need and then she would not have had to have both a medical abortion and a surgical abortion.

Q. Is it your understanding that PPSAT only offers the patient the option of a surgical abortion in this circumstance?

A. That's not what I said here. What I said is that the patient has already undergone a medical abortion and now, because she did not have an ultrasound to triage her to the appropriate diagnostic category, she has to have a surgical abortion in addition to her medical abortion.

Q. Well, what is your basis for saying that she has to have just now or in the report she

must now undergo a surgical abortion?
A. Because that's what their protocol says. It says that if the hCG is elevated, they would now do a surgical abortion. If there were -- was no -- if there were no chorionic villi or gestational sac on that surgical abortion, then she would have to go and be seen for an ectopic preg- -- to diagnose an ectopic pregnancy, whereas, if they had done the transvaginal ultrasound initially and said, okay, this is either -- we -- we don't -- this is either a -- we can't really tell what this is, this could be a miscarriage, this could be an ectopic pregnancy, it could be an intrauterine pregnancy, and had tri- -- triaged her to the appropriate diagnostic category, she would not have had to undergo those procedures and pay for both of those.
Q. So my question is, if a patient returns after a medication abortion with high hCG levels, you believe the only option PPSAT says to her is a surgical abortion?
A. No.
Q. What else do they offer her?
A. First of all, again, I'm not talking about --

I am talking about in the pre- -- patient with a pregnancy of unknown origin where you -- they did not do a screening ultrasound to ascertain the location of the pregnancy. If they then -- they did not do that ultrasound, she comes back with high hCG levels, they have no basis -- no diagnostic basis for -- to have triaged her into one of those three categories, then their own protocol says that they perform a surgical abortion.

Q. You believe that the protocol only includes a surgical abortion at that point?

A. No. That's not what I'm saying. I'm saying that is what their protocol says is part of their algorithm.

Q. Do you believe a physician provides substandard care if they do not provide every medical service a patient might need?

A. I don't -- I think that that's a -- it's a question that I really can't answer because it's -- a patient's perception of need has nothing to do necessarily -- or may not have anything to do with actually what's medically appropriate.

Q. When you treat patients, do you occasionally refer them for services that you do not provide?
A. Yes.
Q. Do you think that that's a shortcoming of your medical practice?
A. Well, not so much in my current medical practice, actually --
Q. It's something --
A. -- because I'm a hospitalist and my primary responsibility is patients in labor.
Q. Do you believe that a physician who practices in an outpatient setting and refers a patient for medical services that physician does not provide is deficient in some way?
A. Not necessarily. Depends on the clinical situation.
Q. Are you aware of any early medication abortion patients who have experienced negative outcomes from an ectopic pregnancy as a result of PPSAT's protocol?
A. No.
Q. In Paragraph 351 of your report --
A. Yes.
Q. -- you discuss a study by Barnhart, et al.,

correct?

A. Yes.

Q. And you say -- one moment. And -- okay. Actually, Paragraph 354 you say in reference to this study that, Performing a medical abortion without identifying the location of pregnancy goes against the recommendations in this paper.

Where in Barnhart, et al., do they discuss medication abortion?

A. They talk -- it's -- it's -- the point that I'm trying to make there is not Barn- -- whether Barnhart discusses medication abortion. The point -- the overarching and much bigger point and the reason why there is an enormous literature on pregnancy of unknown location is that you must triage a patient -- as it says in Paragraph 353, Pat- -- patients must have an ultimate diagnosis of an IUP, an ectopic pregnancy, or spontaneous resolution of a pregnancy.

That is the point that I'm trying to make. It's not whether they mention medication abortion or not. It is simply one of the best studies that synthesizes the

available consensus on pregnancy of unknown location.

Q. So does the paper discuss medication abortion at all?

A. It doesn't discuss it, but that's not why I included it. The reason I included it here is because it clearly states unequivocally and as consensus that pregnancies of unknown location must be appropriately diagnosed -- triaged into appropriate diagnostic categories. That is the important point that I'm trying to make here.

Q. I know you say that you are a hospitalist now, but did you provide treatment to patients in an outpatient setting?

A. Yes.

Q. Did you provide prenatal care to patients in an outpatient setting?

A. Did I?

Q. Yes.

A. Yes.

Q. When you did provide prenatal care to outpatients, at what point in pregnancy do you typically begin seeing them for prenatal care?

A. I started seeing them sometimes from very soon after they had a positive home pregnancy test.
Q. Can you estimate about how many weeks since the patient's last menstrual period that would have been?
A. So typically, for most women, they present for care if they've done a home pregnancy test early because they -- they -- when they come in to see -- see us, it's typically sometime between six and ten weeks I would say.
Q. And when you provided prenatal care in an outpatient setting, when would your patients typically receive their first ultrasound?
A. As soon as they came in or maybe within a week after they came in if they couldn't stay for an ultrasound.
Q. And what sort of ultrasound was that?
A. Usually transvaginal -- abdominal and if, you know, we couldn't see anything, then transvaginal.
Q. And in Paragraph 358 of your declaration you discuss -- well, apologies. You -- you first cite the study in Paragraph 356 but are

discussing it there, a study by Borchert, et al., correct?
A. Yes.
Q. And that is coauthored by Dr. Boraas, an expert witness for plaintiffs in this case, correct?
A. Yes.
Q. And you assert that, With a high loss-to-follow-up rate, no conclusions can be drawn related to risks for complications, right?
A. Yes.
Q. Is there anything in the paper that you read that suggests the patients who were lost to follow-up were different in any meaningful way from the ones who remained in the study?
A. You can't say. They -- they were lost to follow-up so you can't say.
Q. Do you think that there was any information taken about those patients initially?
A. I think that some information was taken, but there's absolutely no way to determine from the paper how the patients -- how the distribution of risk factors or sociodemographic factors or anything else

differed between the patients lost to follow-up versus the ones that stayed.

Q. Dr. Wubbenhorst, you submitted a report to the Inter-American Court of Human Rights, correct?

A. Yes.

Q. And that was specifically an expert opinion in support of the Republic of El Salvador in a legal challenge to the application of its abortion ban for a woman known as Beatriz, correct?

A. Yes.

Q. Is it fair to say that you support El Salvador's abortion laws?

A. Yes.

Q. Are you aware that abortion in El Salvador is illegal in every circumstance?

A. Yes.

Q. Are you aware that it is punishable by up to 40 years in prison?

A. Yes.

Q. Are you aware that there are dozens of women currently imprisoned in El Salvador?

A. I was not aware of that.

Q. Do you believe that pregnant women in North

Carolina who seek and obtain abortions should be criminally prosecuted?

A. I think I said earlier in this deposition that I do not believe that women should be prosecuted. If I didn't say it then, then I'm going to say it now. I think that we need compassion for women. We need to help them to see that there are alternatives to abortion and help provide the -- that -- those alternatives, whether it's financial, whether it's walking with them through pregnancy. In talking with many, many women who were looking at having abortions, the number one thing they have said to me is, I have no one to go with me through this pregnancy. So I think that if we can provide that, that's what we do. I do not agree in prosecu- -- -cuting women or putting them in jail just to be very clear.

Q. If you don't agree with that, then what motivated your expert opinion -- or what motivated you to submit an expert opinion in support of a country that does such a thing?

A. I'm not a lawyer and I don't necessarily agree with that, but the goal -- the stated

goal of the challenge to El Salvador's law was to create abortion on demand at any gestational age. The people challenging the statute were very clear that that was what they were trying to do. I do not agree with that. How El Salvador deals with the question of pregnant women who have abortions is -- I don't nec- -- I do not agree with that. I'll be very clear with that. But I do not agree that their laws should be overturned -- and not just El Salvador but the rest of Latin America -- their laws should be overturned to allow abortion on demand at any gestational age.

Q. Do you believe that Beatriz was seeking abortion on demand at any age?

A. I'm very familiar with the case. She was not. She was seeking the -- looking for an abortion because her child had anencephaly. However, as I've just said, the people who are seeking to overturn -- -turn the laws have made it very clear in multiple arenas that that was their goal.

Q. But Beatriz's family was a participant in this litigation, correct?

A. The -- I don't know. I don't know.
Q. It's also true that Beatriz suffered from lupus, correct?
A. That's correct.
Q. And isn't it true that women with lupus occasionally suffers negative pregnancy outcomes as a result of the lupus?
A. But I'm going to return to something I said earlier. You cannot predict whether a given woman -- all of our strategies around risk are population-based risk stratification strategies. They do -- cannot predict whether a single patient will undergo a complication. And in her case, she did not.
Q. And my question is whether a woman with lupus -- at a population level, women with lupus, if they face higher risks of complications during their pregnancy as a result of lupus.
A. They do. And if those complications occur, then we intervene appropriately.
Q. And do those women also experience a higher rate of death during pregnancy as a result of lupus?
A. With good medical care, it is very unusual.

And as I've said, if a woman develops complications like nephritis, encephalitis, any other complication from lupus, we intervene urgently and do what is best for the mom.

Q. Do you believe that El Salvador is a place that provides good medical care to women with lupus who are pregnant?

A. From reviewing the -- her chart, which I did, I reviewed her chart in its entirety, yes, they provided excellent medical care.

Q. She had a C-section at 26 weeks, correct?

A. That's correct.

Q. Do you believe that is the standard of care for a woman who seeks an abortion at 13 weeks because of health concerns?

A. It has nothing to do --

MR. BOYLE: Objection to form. You can answer.

A. It has nothing to do with abortion. It has to do with the clinician's assessment of what was the appropriate management for her at that stage.

Q. If Beatriz decided that she didn't want to bear the risk, whatever it might be, for any

individual woman with lupus --

A. Bear the risk of what?

Q. A negative complication or death from lupus during pregnancy, the standard of care is to deny her an abortion you feel?

MR. BOYLE: Objection to form. You can answer.

A. I don't think we're talking about a standard of care; we are talking about the law. The law states that abortion is illegal. If she had a complication and she needed to have urgent delivery, that is not an abortion. I've made that clear previously and I think you understand that. That is not an abortion. That is simply acting to preserve the life of the mother, but the intent is not to kill the -- the infant.

Q. But you did refer to good medical care that met the standard of care that Beatriz allegedly received, correct?

A. Because I reviewed the chart and I felt that she did receive good medical care.

Q. And you say that that care helped her achieve a goal of good medical care during pregnancy, correct?

MR. BOYLE: Object to form.

A. I don't understand your question.

MR. MENDIAS: So I can -- I'll mark this as an exhibit. Thank you.

(WUBBENHORST EXHIBIT O, Expert Opinion Report, Dr. Monique Chireau Wubbenhorst, Beatriz, was marked for identification.)

MR. BOYLE: Thank you.

MR. MENDIAS: Uh-huh.

A. Great. Thank you for providing this.

Q. Uh-huh. So on Page 38 of that report, the first nonindented paragraph, the one that begins, Like other women --

A. Yes.

Q. -- can you read the first two sentences --

A. Uh-huh.

Q. -- of that paragraph.

A. Like other women, Beatriz had the right to enjoy a good state of health to the extent possible given her lupus. Good medical care that met the standard of care helped her achieve that goal during her pregnancy.

Q. So you believe her goal was to have an emergency C-section at 26 weeks?

A. I'm not understanding your question. If

she -- she -- that was not her goal, but that was an outcome of her pregnancy based on the clinicians that were caring for her. And in my review of the chart, that was an appropriate decision.

Q. Her goal was to have an abortion at 13 weeks, wasn't it?

A. I can't -- I'm not speaking to that question of what her goal was or what her goal was not. The question here is good medical care met the standard of care that helped her achieve the goal of having a -- a good state of health during pregnancy. That is the question that I am opining -- I opined on in here.

Q. Do you believe that the risks of a C-section at 26 weeks of pregnancy are greater than the risks of an abortion at 13 weeks of pregnancy?

A. Again, I don't think that that is a relevant concept here. She continued her pregnancy. She needed an emergency cesarean section at 26 weeks for indications that were well understood, that were -- reflected good medical care. It was -- would have been

impossible to foresee that she was going to need a cesarean section at 26 weeks and so, therefore, you can't compare the outcome of her having an emergency C-section with the outcome of her having an abortion. She had good care. She got, from my viewpoint -- again, reviewing the chart in detail, she had good care and when it was necessary to deliver the baby, this was the mode of delivery that was chosen.

Q. Okay. But my question was whether the -- you believe that the risk of complications is higher from a 13-week abortion than a C-section at 26 weeks.

A. No. I think the risk of complications is higher for -- I think the com- -- risk of complications is higher for an -- for a cesarean section 26 weeks, but I don't think that's relevant to the question here.

Q. But she sought an abortion at 13 weeks, correct?

A. That's correct.

Q. And if she had been permitted to obtain an abortion at 13 weeks, the risk for complications for a 13-week abortion would

have been relevant to her, correct?
A. I don't think so because, again, she could have had an abortion at 13 weeks and had perforation, had infection, had hemorrhage. She could have had any one of a number of outcomes. As I've said, risk is population stratified. You cannot say what could or could not have happened. That's speculative. I can't respond to that.
Q. The population of women having C-sections at 26 weeks undergo much higher risks of complications than the population of women --
A. But we're not --
Q. -- obtaining abortions --
A. -- talking about --
MR. BOYLE: Object. Object to form.
BY MR. MENDIAS:
Q. -- at 13 weeks.
A. We're not talking about --
MR. BOYLE: Object to form.
THE WITNESS: Okay.
MR. BOYLE: You can answer.
THE WITNESS: Thank you.
A. We're not talking about population; we're talking about her. You can't say that she

would have had no risk to an abortion at 13 weeks. You can't say that. And she didn't have any complications from her cesarean section at 26 weeks. She died in a car accident a few years later.

Q. Do you believe that her death was attributable to the fact that she wanted an abortion?

A. No. She died in a car accident.

Q. In Paragraph 47 of your report you say that, Black women have two to three times higher mortality from abortion compared to white women.

A. Give me -- give me a chance to get there. Give me a chance to get there. Yes.

Q. Do you know if black women also have a higher mortality from childbirth than white women?

A. Yes, they do.

Q. Why would the mortality rate be higher for black women from both abortion and childbirth?

A. Because I think there are underlying comorbidities that are more common in African-American women, in particular diabetes and hypertension. I think the other

reason that it's difficult to make that comparison is that if you look at maternal mortality statistics, the morbidity and mortality for African-American women tends to cluster in older ages and typically, women undergoing abortion -- late abortion may be older as well, but that discrepancy is most likely due to -- although it's -- you know, there's -- this is a very active area of research. -- that those differences are probably due to the distribution of underlying health factors and possibly to access to care as well.

Q. And in Paragraph 19 of your declaration you reference, the deliberate targeting and destruction of 17 million African-American lives through abortions since Roe; is that right?

A. Yes.

Q. Who deliberately targeted African-American women for abortion?

A. I think that if you look at the history of -- of abortion and specifically population control, it is very clear that black women and African-Americans in general were seen as

the other -- especially in eugenic terms. That's going all the way back to Galton and Darwin and those other folks. But as you continue that thread through the 20th century, Fredrick Osborn said that abortion is turning out to -- and contraception turning out to be great eugenic advances of our time. Others have said that abortion is -- I think it was Lawrence Lader said that abortion is -- is -- is especially useful given in minorities who are likely to rise up in armed rebellion. So you have a consistent thread of a worldview that says that African-Americans are subhuman and, therefore, that the -- that abortion can -- has the potential for being a eugenic tool of injustice.

Now, I want to be very clear in saying that I am not saying that individual abortion providers have eugenic intent in performing abortions. I want to be very clear in saying that. What I am saying is that the outcomes of policy, especially as -- and practice especially as they are related to abortion have led to eugenic outcomes, namely, that

most abortions occur in African-Americans even though we constitute only 13 to 14 percent of the population, that the African-American population principally because of abortion is in decline and has been since the 1990s in terms of the number of births every year.

So that's the point that I'm trying to make, not attributing intent to anyone because I can't know someone's intent, but the outcome remains the same.

Q. Is it possible to have deliberate targeting without intent?

A. I think you can -- again, I'm looking at the outcome.

Q. Do --

A. I understand -- I understand what you're saying, but, again, if the result is that you have this enormous racial disparity in abortion, I can't ascertain intent, but the eugenic outcome is -- remains the same.

Q. And you can't ascertain whether it's deliberate, correct?

A. What's that?

Q. And you couldn't ascertain whether the

discrepancy is deliberate?
A. Then how else would you arrive at the -- at the discrepancy if it's not deliberate on some level and --
Q. So the --
A. -- and especially if policy, especially population control policy, has been directed in -- in -- along those lines --
Q. Since --
A. -- since --
Q. -- 1972 -- '73?
A. No. Since -- since before that. Since the Nixon era and since the 1960s. This -- this antedates 1973. This has been going on for a while.
Q. Okay. So, Doctor, I'm curious specifically who you say is deliberately targeting and destroying 17 million African-American lives.

Can you identify who's doing that deliberate targeting?
A. I think that -- again, I am looking at the outcome and I am looking at the fact that, whether we like it or not, that disparity exists. Whether we like it or not, the ugly fact is that we have had 17 million

African-American lives destroyed, that we are looking at the decline in the number of births to African-American woman -- women, that for every three births to African-American women that occur, there are two abortions.

So whether an individual practitioner makes a deliberate -- is deliberately targeting African-Americans, I don't know. That may be true; that may not be true. But as a policy statement, the net out- -- the net outcome is the same.

Q. Do you believe that African-Americans who obtain abortions are complicit in eugenics?

MR. BOYLE: Objection.

BY MR. MENDIAS:

Q. You can answer.

A. I'm not -- I don't know what that statement means. How can you be complicit in eugenics because eugenics is a worldview? Eugenics says that one group of people is human and one group of people is not human and because this group of people is not human, you can subject them to anything, any kind of mistreatment, any kind of suppression.

That's -- that's the essence of eugenics as defined by Galton in his speech in 1901. He was very clear, according to Darwinian theories, that some people were the fit and others were not the fit. And the slogan of the -- one of the slogans of the American Eugenics Board was less from the fit -- less from the unfit, more from the fit. That's one of the goals of eugenics.

Q. Changing topics a little bit, Doctor, what is, in medicine, an off-label use?

A. It's when a medication has been approved for one specific indication but physicians use it for another indication.

Q. Have you ever prescribed medications for uses that differ than what's on their FDA-approved label?

A. Yes. This is something, actually, that -- for a number of different medications, using nifedipine to control blood pressure in pregnancy. There's -- there's a list of -- of those -- of those medications.

Q. Is off-label use common in obstetrics and gynecology?

A. I can't speak to how it's common -- whether

it's common or uncommon. I know that it's something that I do and that many of the clicians -- clinicians that I know do as well.

Q. In going back to something we talked about much earlier today, you mentioned that you had seen -- that you had treated patients who were suffering from postabortion complications outside the United States; is that right?

A. Yes.

Q. Where did you treat those patients?

A. Kenya.

Q. Is abortion legal in Kenya?

A. No. Well, it's -- the current status is that it's -- I believe it's legal with restrictions. I would have to check on the exact -- the laws changed recently.

Q. Was abortion legal in Kenya when you treated these patients?

A. Yes --

Q. How --

A. -- for specific indications. And the patients that I treated were actually not -- had not been aborted by, like, back alley

abortions or, you know, self-abortions. The abortions were carried out by NGOs, nongovernment organizations, who had set up abortion clinics in those areas and then when their patients -- when those patients had complications, they would -- they would come in and be seen.

Q. Did you ever report NGOs performing illegal abortions in Kenya to anyone?

MR. BOYLE: Object to form. You can answer.

THE WITNESS: What's that?

MR. BOYLE: Object to form. You can answer.

A. Yeah, I don't know what the indication was for the abortions.

Q. So another topic. We discussed earlier forensic use of the products of conception after an abortion to identify a rapist.

A. Yes.

Q. Do you remember that? Do you know what protocol PPSAT follows for maintaining a chain of custody when it provides an abortion to someone who's been a victim of rape?

A. No.

Q. You believe that a major flaw in studies demonstrating the safety of abortion is that they don't include review of patient medical charts, correct?

A. I wouldn't say it's a --

MR. BOYLE: Object to form.

THE WITNESS: Okay.

MR. BOYLE: You can answer.

THE WITNESS: Okay. Thank you.

A. No, sir. I wouldn't say that it's a major flaw because sometimes I think you have to work with the data that you have and sometimes the data that you have is not perfect.

MR. MENDIAS: Can I ask how long we've been --

THE REPORTER: I have three hours.

MR. MENDIAS: Three hours. Do you want to take a brief break?

THE WITNESS: Thank you, sir. That would be great. Another bathroom break would be great. Oops. Wait.

THE VIDEOGRAPHER: Going off the record. The time is 4:46.

(Whereupon, there was a recess in the

proceedings from 4:46 p.m. to 5:04 p.m.)

THE VIDEOGRAPHER: Back on the record. The time is 5:04.

MR. MENDIAS: So, Counsel, I'd just like to request given that Dr. Wubbenhorst stated that she has an updated CV if, Ellis, you could provide that by the end of the week.

THE WITNESS: No problem at all. Yeah.

MR. MENDIAS: Wonderful.

THE WITNESS: Uh-huh.

BY MR. MENDIAS:

Q. Okay. So, Doctor, you testified that abortion patients with complications do not frequently return to the clinic that provided the abortion; is that correct?

A. That's correct.

Q. What's your basis for that statement?

A. I believe it's in my declaration that ACOG noted that 50 percent or fewer of patients returned to clinic following their abortion.

Q. Do you know what year that ACOG statement is from?

A. I'd have to look in here.

Q. Do you know if that's examined data from

North Carolina?

A. I don't know if that was including Nor- -- data from North Carolina.

Q. And going back to our conversation about intrauterine adhesions after a D&C, you remember that, correct?

A. Yes.

Q. So I think I asked how frequently your patients had developed intrauterine adhesions, but I just wanted to clarify.

Have any of your parent -- patients that you've provided a D&C to developed such adhesions?

A. So I have cared for women who have developed intrauterine adhesions following prior D&C. I have not seen my -- any of my own patients who I performed D&C on return with intrauterine adhesions.

Q. Is it possible that they sought care for intrauterine adhesions from other providers?

A. I think that's possibly it. I think it's also that I've practiced in a lot of geographic locales over, you know, the last 30 years so it's entirely possible that if they developed them, they could have seen

another provider.

Q. And what does it mean if a patient has developed an intrauterine adhesion in terms of consequences for her health?

A. So with Asherman's syndrome, intrauterine -- intrauterine adhesions, they're associated with infertility and dysfunctional uterine bleeding.

Q. Do you characterize that as a serious condition?

A. With -- in the case of dysfunctional uterine bleeding and -- I -- and I -- there's another entity with which they're associated and that's abnormal placental adherence and that's actually quite serious.

Q. How frequently do patients develop abnormal placentation as a result of Asherman's syndrome?

A. I think that I describe that in my statement and I can take a look and see, but the real question was not so much the frequency because, again, it's hard to get at the frequency. It's that when patients develop intrauterine adhesions, they are at higher risk for going on to have abnormal

placentation and -- leading to adhering placenta, which is a real obstetrical problem.

Q. When you provided prenatal care to patients, did you tell them about ectopic pregnancy?

A. I am not following your argument.

Q. Well, it was a question. When you --

A. I mean, your question. I'm not following your question. Sorry.

Q. When you provided prenatal care to your patients -- you remember testifying that you did that, correct?

A. Yes. Yes.

Q. Did you counsel them on symptoms of ectopic pregnancy?

A. If they came in and they did not have a -- a pregnancy that could be seen in the uterus on ultrasound, definitely.

Q. And what did you say to them as part of that counseling?

A. So if we did not see a pregnancy on -- then we would warn them that they might have a -- a -- an ectopic pregnancy, describe what an ectopic pregnancy was, what the risks were. And then they would return within 48 hours so

that we could rescan them and recheck their hCG.

Q. Did any patients not return?

A. I've never had a patient not return.

Q. What symptoms would you counsel them to look for concerning a ruptured eptoc- -- ectopic pregnancy?

A. Well, I think that it's important to make a distinction here between symptoms of ectopic pregnancy which are transient and fleeting -- and, in fact, I wrote a paper -- cowrote a paper in the Journal of American Medical Association some years back that looked at the unreliability -- how reliable were different symptoms.

So the diagnosis of a ruptured ectopic pregnancy is fairly straightforward. Women will often say they felt a pop, they experienced terrible pain in their right side, and they may feel faint. But one of the problems that arises with that is that they don't always associate that with -- they think, oh, I have, you know, a ruptured cyst or something like that. And so the real danger is that they are not symptomatic

enough that they seek medical care and they bleed and bleed. And healthy young women have an amazing ability to adapt to loss of blood, but once they run out of those adaptive capabilities, they just die. So this is why diagnosing ectopic pregnancy is so treacherous. Yes, if they rupture, it's a little bit more straightforward, but even sometimes when they're rupturing, it's not until they become faint or pass out or have some other complication. And before that, it's -- it's -- it's very protean. It can be very difficult. They can -- they can have bleeding that looks like a miscarriage and they'll think that they've miscarried, for example.

Q. At what point in pregnancy does ectopic pregnancy typically present on an ultrasound?

A. So are you talking about at what point in pregnancy is it typically diagnosed, sir? Is that what you're saying?

Q. Sure.

A. Right. So usually, about the same time plus -- you know, plus a few weeks as you see an intrauterine preg- -- that you might

expect that you would see an intra- -- inter- -- intrauterine pregnancy you could potentially see an ectopic pregnancy. Again, the problem is that even with skilled hands, it depends on -- very much on the hCG level and there's some -- it depends on the hCG level and there are sort of formulae or algorithms that you use.

Q. So throughout your medical career as an attending, did you train medical residents?

A. Yes.

Q. Has a medical resident ever lodged a complaint about you?

A. No.

Q. Throughout your medical career have you ever faced any disciplinary action --

A. No.

Q. -- from a hospital?

A. No.

Q. Have you ever received any disciplinary or remedial action from a hospital?

A. No.

Q. Have you ever received any disciplinary action from a state medical board?

A. No.

Q. You were with the faculty of Duke University School of Medicine from 2003 to 2018?
A. Yes.
Q. It's correct that this is where you practiced medicine for the significant majority of your medical career, correct?
A. Yes.
Q. Under what circumstances did you leave Duke?
A. I was recruited starting in fall of 2017 to the U.S. Agency for International Development.
Q. How would you characterize your relationship with Duke when you left?
A. I would say that it wasn't great. I think that the -- it was hard to totally assess this, but I had a sense that they were not -- you know, they were -- people were not in favor of the pro-life work I was doing.
Q. What led you to that conclusion?
A. I think that people would say things to me.
Q. Such as?
A. You know, what -- what's the -- you know, why are you doing this, you know, that type of thing.
Q. So you weren't asked to resign from your

position at Duke?

A. No. No, I was not asked to resign.

MR. MENDIAS: Okay. I think that's all the questions that I have.

MR. BOYLE: Give me just a moment, if you would --

MR. MENDIAS: Sure.

MR. BOYLE: -- please. If -- if anyone on the Zoom has any questions, I'll -- I'll defer to y'all.

This is Ellis Boyle on behalf of the legislative leader defendants. I don't have any questions and I don't hear any from the Zoom so unless -- I -- I guess that concludes the deposition.

THE REPORTER: Sam?

MR. MENDIAS: Thank you very much, Doctor.

THE WITNESS: Okay. Thank you.

THE VIDEOGRAPHER: Anybody on the Zoom?

MR. BOYLE: No. I think -- I think we're -- we're clear. You can go off the record. Thank you.

THE VIDEOGRAPHER: This concludes the deposition. We're going off the record. The

time is 5:15.

[SIGNATURE RESERVED]

[DEPOSITION CONCLUDED AT 5:15 P.M.]

A C K N O W L E D G E M E N T O F D E P O N E N T

I, MONIQUE WUBBENHORST, M.D., M.P.H., declare under the penalties of perjury under the State of North Carolina that I have read the foregoing 187 pages, which contain a correct transcription of answers made by me to the question therein recorded, with the exception(s) and/or addition(s) reflected on the correction sheet attached hereto, if any.

Signed this, the _____ day of _____, 2023.

_____

MONIQUE WUBBENHORST, M.D., M.P.H.

State of:_____

County of:_____

Subscribed and sworn to before me this _____ day of _____, 2023.

_____

Notary Public

My commission expires:_____

E R R A T A S H E E T

Case Name: Planned Parenthood South Atlantic, Et Al. vs. Joshua Stein, Et Al.

Witness Name: Monique Wubbenhorst, M.D., M.P.H.

Deposition Date: Wednesday, August 30, 2023

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Signature Date

STATE OF NORTH CAROLINA)
) C E R T I F I C A T E
COUNTY OF WAKE)

I, LISA A. WHEELER, RPR, CRR, Stenographic Court Reporter and Notary Public, the officer before whom the foregoing proceeding was conducted, do hereby certify that the witness whose testimony appears in the foregoing proceeding was duly sworn by me; that the testimony of said witness was taken by me to the best of my ability and thereafter transcribed by me; and that the foregoing pages, inclusive, constitute a true and accurate transcription of the testimony of the witness.

I do further certify that I am neither counsel for, related to, nor employed by any of the parties to this action and, further, that I am not a relative or employee of any attorney or counsel employed by the parties thereof, nor financially or otherwise interested in the outcome of said action.

This the 4th day of September, 2023.

_____

Lisa A. Wheeler, RPR, CRR
Notary Public #19981350007

D

Q